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2nd Annual Midwestern Mental Health in Corrections Symposium

May 27-29, 1992

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Relapse Prevention: Focus on Treatment

Keynote Speakers:

G. Alan Marlatt

William Pithers

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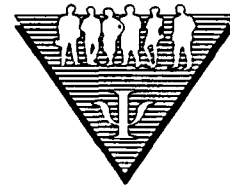
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Mental Health in Corrections Symposium Steering Committee



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Greetings:

On behalf of the Symposium Steering Committee I would like to welcome you to the Symposium and to Kansas City. We hope that this event provides each of you with a unique opportunity to learn and dialogue with colleagues from other institutions.

The Symposium reflects not only the serendipitous confluence of a number of forces but also the commitment of numerous people to the conviction that mental health practitioners in the correctional environment have a unique and important mission. As therapists in prison environments many of us have undoubtedly felt we have been charged with treating the untreatable, remembering the forgotten, and predicting the unknowable. That sense of Quixotism can be compounded by the feeling that, on a daily basis, we work in relative isolation, estranged as "Others" by inmates and correctional staff alike. Perhaps the lessons learned and experiences shared during this event can help each of us remember that those feelings are not necessarily reality.

Special gratitude is due to Colonel William Hart, Commandant, United States Disciplinary Barracks, and Gary, Henman, warden, United States Penitentiary, Leavenworth for their continued support. Without their commitment to the ideal that mental health treatment is important to the rehabilitation of offenders and ultimately to the protection of the society in which we live, this Symposium would not be possible.

Thanks are also due to those scholars, therapists, and other professionals who have expended time, energy, and resources to prepare the many presentations comprising the varied and full Symposium agenda. We appreciate the cooperation of the sponsors and cosponsors for their assistance in accreditation and provision of technical support. We also extend our heartfelt thanks to the many unrecognized members of our staffs and families who have buoyed our sometimes flagging efforts.

Again, on behalf of the Symposium Steering Committee, welcome!



Bruce A. Leeson, Ph.D.

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LEGAL DEVELOPMENTS IN THE CONSTITUTIONAL RIGHT
TO HEALTH CARE

BY

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**Legal Developments in the Constitutional Right
to Health Care**

**2nd Annual Midwestern Mental Health in Corrections Symposium
(Kansas City, May 1992)**

I. PRISONERS' CONSTITUTIONAL RIGHT TO HEALTH CARE.

- A. The Magna Carta (first document to restrain the sovereign).
- B. The Eighth Amendment.
 - 1. Prohibition of torture.
 - 2. Evolution of standards in accordance with "contemporary notions of decency and dignity."
 - 3. Twentieth Century applications.
 - a. Failure to relieve pain.
 - b. Failure to restore function.
- C. Estelle v. Gamble: "Deliberate indifference to serious medical needs."
 - 1. Conceptual difficulties with the legal standard.
 - 2. Accidents, malpractice, and professional disagreements distinguished.
 - 3. "Gross departure" from professional standards.
 - 4. State of mind and the relevance of "good faith" (Wilson v. Seiter).

II. INDIVIDUAL COMPLAINTS V. SYSTEMIC ANALYSIS.

- A. A sequence of individual failures closely related in time.

- B. Deficiencies in resources, procedures, and structures such that unnecessary suffering is inevitable.

III. THREE BASIC RIGHTS.

A. The right to access to care.

1. Emergencies.
2. Sick call.
3. Specialists and "outside" care v. second opinions.
4. Infirmary care and rounds.
5. Hospitalization.
6. Therapeutic trials - see 45 C.F.R. Part 46.
7. Prophylactic v. preventive care.
 - a. Treatment to prevent progression of disease.
 - b. Case specific preventive care: gynecological care and dental prophylaxis.

B. The right to care that is ordered.

1. Protocols, treatment plans and guidelines.
2. Specific orders.
3. Specialists' orders.

C. The right to a professional medical judgment (decisions concerning the nature and timing of medical care made by medical personnel, using equipment designed for medical use, in locations conducive to medical functions, and for reasons that are purely medical).

IV. THE RIGHT TO BE FREE OF MALPRACTICE.

A. Adherence to prevailing standards of care in the community.

B. General practitioners v. specialists.

V. PECULIARITIES OF PRACTICE IN THE CORRECTIONAL SETTING.

A. Restraints on the doctor/patient relationship.

1. Informed consent and the right to refuse care: the difficulty of distinguishing refusal from denial.
2. Confidentiality: the communications of medical needs and the protection of medical information.

B. Administrative and security imperatives affecting medical judgment.

1. General schedules for work, exercise, and diet.
 2. Medication.
 3. The inability to self-treat.
- C. Medical staff involvement in custodial and supervisory functions.
1. Work, housing assignments, programs.
 2. Activities "adverse" to patients.
 - a. Body cavity searches.
 - b. Monitoring health conditions of inmates under discipline.
 - c. Forensic testing for drug and alcohol use.
 - d. Forensic psychiatric evaluations.
 - e. Witnessing use of force.
 - f. Disciplinary isolation and other involvement in deciding upon or monitoring punishment.
 - g. Security restraints.
 - h. Execution.
- D. Resources and tailoring of medical judgment of meet conditions of scarcity.
1. "Demand" or "first-come-first-see" or "loudest complainer" system.
 2. "Priority/triage" system.
- E. Relationship to the larger medical community.
1. Licensing.
 2. Accreditation.
 3. Peer review and quality assurance.

VI. PARTICULAR APPLICATIONS.

A. Mental health care.

1. Deference to professional judgment (Youngberg v. Romeo).
2. Application of the Estelle standard.
3. Crisis intervention.
4. Hunger strikes.
5. Suicide and suicide prevention.
6. Self mutilation and aggression.
7. Restraint and seclusion.
8. Involuntary psychiatric hospitalization (Vitek v. Jones).
9. Involuntary administration of anti-psychotic medication (Washington v. Harper).
 - a. Patient with serious mental illness; dangerous to self or others; treatment likely to help.

- b. Procedural protections: psychiatric approval; hearing before "uninvolved practitioners; opportunity to present evidence and cross-examine (without attorney); judicial review.
 - 10. Seizure disorder patients.
 - 11. Mental health factors in inmate discipline.
 - 12. Duty to warn (Tarasoff v. Regents of the University of California).
- B. Dental care.
- C. AIDS.
 - 1. Prevalence of patients with history of risk behavior in prisons.
 - 2. Hysteria.
 - 3. Testing.
 - a. National Commission standards.
 - b. Voluntary; mandatory; as a condition of treatment; anonymously.
 - 4. Confidentiality.
 - 5. Isolation and quarantine.
 - 6. Transmission and education.
 - 7. New treatment modalities.
 - 8. Access to therapeutic trials.
 - 9. Release.
 - 10. Discharge planning.
 - 11. Development of law and policy.
 - a. Anti-discrimination laws.
 - b. Reopening old decrees.
 - c. The right to die and "do not resuscitate" orders.
- D. Medical diets.
- E. Childbirth and abortion.
- F. Drug and alcohol treatment.
- G. Sex offender treatment.
- H. Physically disabled patients.
- I. Mentally retarded and developmentally disabled patients.
- J. The right to die (Cruzan v. Missouri Department of Health).

VII. "CONTRACTING OUT."

- A. Scope: "complete"; "none"; partial (particular services; particular positions).
- B. Effect on legal standards.

- C. Other considerations: vicarious liability; indemnification; insurance; personnel policy.

VIII. ADMINISTRATIVE SYSTEMS AND RESOURCES.

- A. Reception examinations.
- B. Recordkeeping.
- C. Staffing.
 - 1. Inmate health workers.
 - 2. Use of non-health care personnel.
- D. Equipment.
- E. Quality control.

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VICTIM EMPATHY GROUP PROCESS

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VICTIM EMPATHY GROUP PROCESS

STAGE ONE: READING ASSIGNMENTS

STAGE ONE HOMEWORK: SUMMARIZE READING ASSIGNMENTS

STAGE TWO: ORAL READING OF SUMMARIES OF ASSIGNMENTS

STAGE THREE: VIEWING VIDEOTAPES

STAGE THREE HOMEWORK: OFFENSE FROM YOUR VICTIM'S PERSPECTIVE

STAGE FOUR: ORAL READING OF YOUR VICTIM'S EXPERIENCE

STAGE FIVE: ROLE-PLAY OF THE ABUSE

STAGE SIX: VICTIM-OFFENDER MEETING

VICTIM EMPATHY GROUP PROCESS

STAGE ONE: READING ASSIGNMENTS

I NEVER TOLD ANYONE (Bass & Thornton, 1983)
KISS DADDY GOODNIGHT (Armstrong, 1978)
BETRAYAL OF INNOCENCE (Forward & Buck, 1978)
FATHER'S DAYS (Brady, 1979)

STAGE ONE: HOMEWORK

SUMMARIZE THE FEELINGS AND MEMORIES OF THE PEOPLE
WHOSE HISTORIES YOU HAVE READ. COMPARE HOW YOUR
VICTIMS' EXPERIENCES MAY HAVE BEEN SIMILAR TO AND
DIFFERENT FROM THOSE INDIVIDUALS WHOSE
RECOLLECTIONS YOU HAVE READ OR LISTENED TO.

VICTIM EMPATHY GROUP PROCESS

STAGE TWO: READING SUMMARIES ALOUD

CLIENTS READ THEIR SUMMARIES, DESCRIBE THE RELEVANCE
OF THE READINGS TO THEIR OWN VICTIMS, AND RESPOND TO
OTHER GROUP MEMBERS' COMMENTS.

STAGE THREE: VIEWING VIDEOTAPES

WHY GOD, WHY ME?
RAPISTS - CAN THEY BE STOPPED?
VICTIMS FIGHT BACK
CHILD SEXUAL ABUSE

STAGE THREE: HOMEWORK

CLIENTS ARE INSTRUCTED TO WRITE AN ACCOUNT OF THEIR
OFFENSE FROM THE PERSPECTIVE OF THEIR MOST RECENT VICTIM.

VICTIM EMPATHY GROUP PROCESS

STAGE FOUR: ORAL READING OF VICTIM'S EXPERIENCE

EACH CLIENT READS ALOUD IN GROUP HIS ACCOUNT OF HIS VICTIM'S EXPERIENCE. THE OFFENDER MAY REMAIN IN HIS VICTIM'S ROLE OR RETURN TO HIS OWN ROLE AS THE ABUSE AS HE RESPONDS TO QUESTIONS FROM THE GROUP. THIS PROCESS IS VIDEOTAPED AND PLAYED EITHER IN INDIVIDUAL THERAPY OR LATER IN GROUP.

STAGE FIVE: ROLE-PLAY OF THE ABUSE

EACH CLIENT ROLE-PLAYS THE DETAILS OF HIS MOST RECENT OFFENSE. HE BEGINS BY ASSUMING HIS OWN ROLE AS THE ABUSER, WHILE ANOTHER GROUP MEMBER ROLE-PLAYS THE VICTIM AS THE OFFENSE IS RE-ENACTED. AFTERWARD, THE ABUSER IS REQUIRED TO SWITCH ROLES AND TAKE THE ROLE OF HIS OWN VICTIM. GROUP MEMBERS ASK QUESTIONS ABOUT THE OFFENDER'S THOUGHTS AND FEELINGS AS THE ROLE-PLAY OCCURS. THE SESSION IS VIDEOTAPED FOR LATER REVIEW WITH THE OFFENDER.

STAGE SIX: VICTIM-OFFENDER MEETING

IN THE FINAL STAGE OF VICTIM EMPATHY GROUPS, OFFENDERS MAY MEET WITH ADULT SURVIVORS OF CHILD SEXUAL ABUSE OR RAPE. OFFENDERS WHO HAVE NOT DEMONSTRATED EMPATHY ARE EXCLUDED FROM THE MEETING. BOTH OFFENDERS AND VICTIMS ARE INFORMED THAT THE VICTIMS ARE IN CONTROL OF THE MEETING. BOTH GROUPS LEAVE THE SESSION FEELING DRAINED, BUT WITH A SENSE OF HOPE THAT THE FUTURE CAN BE DIFFERENT THAN THE PAST.

RUNNING A RELAPSE PREVENTION GROUP

BY

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RELAPSE PREVENTION GROUP PROCESS

STAGE ONE: EXPLANATION OF THE RELAPSE PREVENTION MODEL
STAGE ONE HOMEWORK: PREPARE LIST OF RISK FACTORS
STAGE TWO: LISTING OF RISK FACTORS
STAGE TWO HOMEWORK: FIVE MOST PROBLEMATIC RISK FACTORS
STAGE THREE: GROUP ANALYSIS OF FIVE MOST COMMON RISK FACTORS
STAGE THREE HOMEWORK: IDENTIFICATION OF CUES
STAGE FOUR: GROUP LISTING OF CUES
STAGE FIVE: BRAINSTORMING COPING RESPONSES
STAGE FIVE HOMEWORK: ANALYSIS OF COPING RESPONSES
STAGE SIX: REVIEW OF OPTIMAL COPING STRATEGIES
STAGE SIX HOMEWORK: PREPARATION OF REMINDER CARDS
STAGE SEVEN: PROCESSING OTHER RISK FACTORS
STAGE EIGHT: TESTING PREPAREDNESS
STAGE NINE: ANALYSIS OF EFFECTIVENESS
STAGE TEN: INFORMING SUPERVISION NETWORK

Two Dimensions of Relapse Prevention

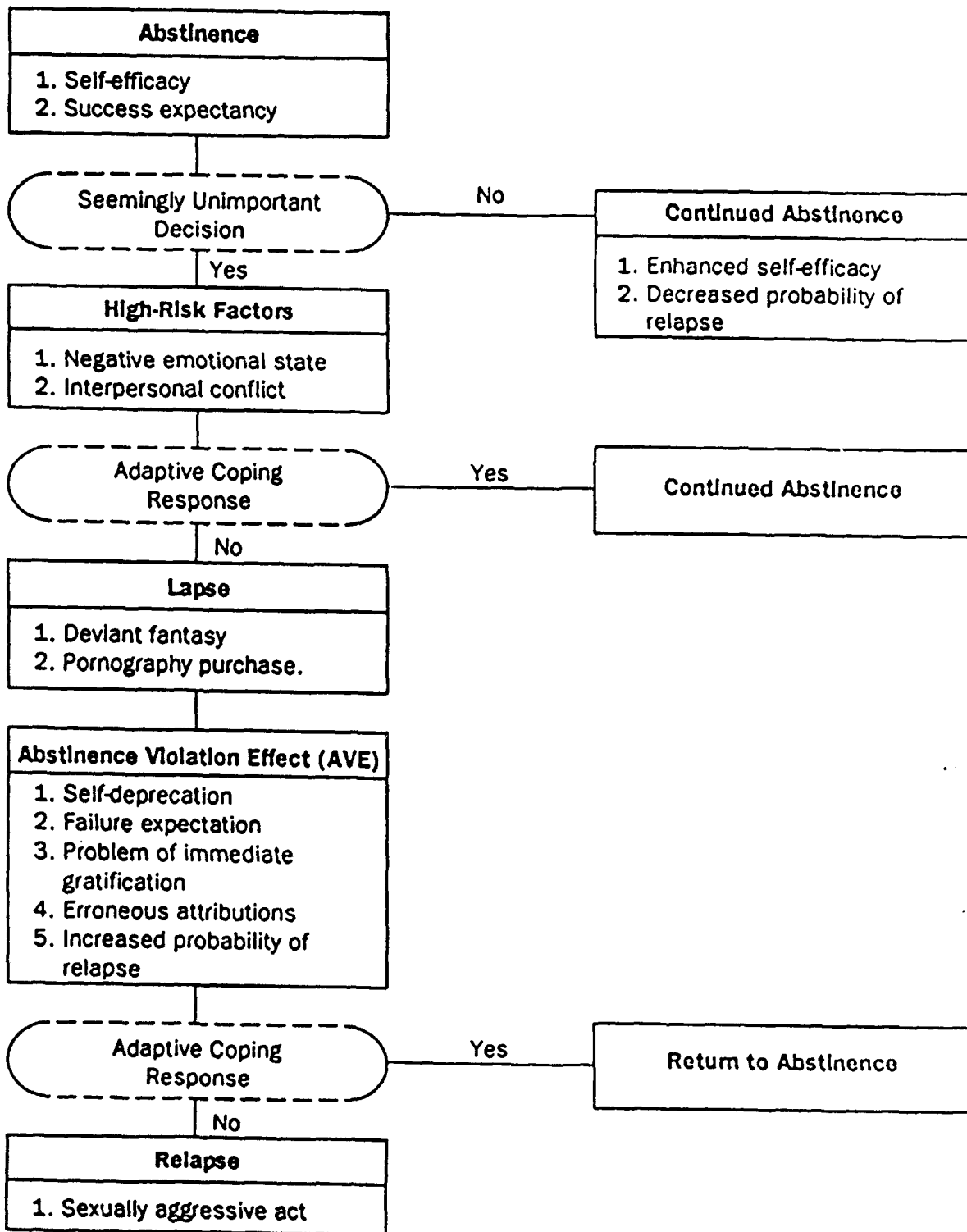
- I. Internal, Self-Management
Dimension
- II. External, Supervisory
Dimension

RELAPSE PREVENTION GROUP PROCESS

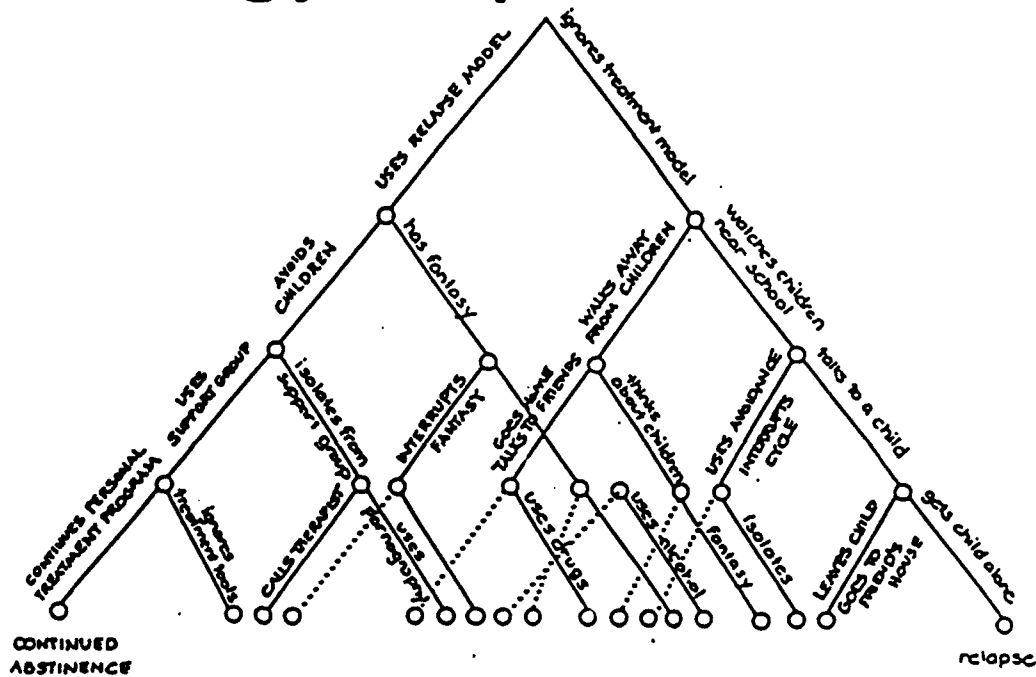
STAGE ONE: EXPLANATION OF THE RP MODEL

PRECURSORS TO SEXUAL AGGRESSION
PLANNED IMPULSIVENESS
SEEMINGLY UNIMPORTANT DECISIONS
HIGH-RISK SITUATIONS
RISK FACTORS
PROBLEM OF IMMEDIATE GRATIFICATION
COPING STRATEGIES
LAPSES
ABSTINENCE VIOLATION EFFECT
RELAPSE

A Cognitive-Behavioral Model of the Relapse Process

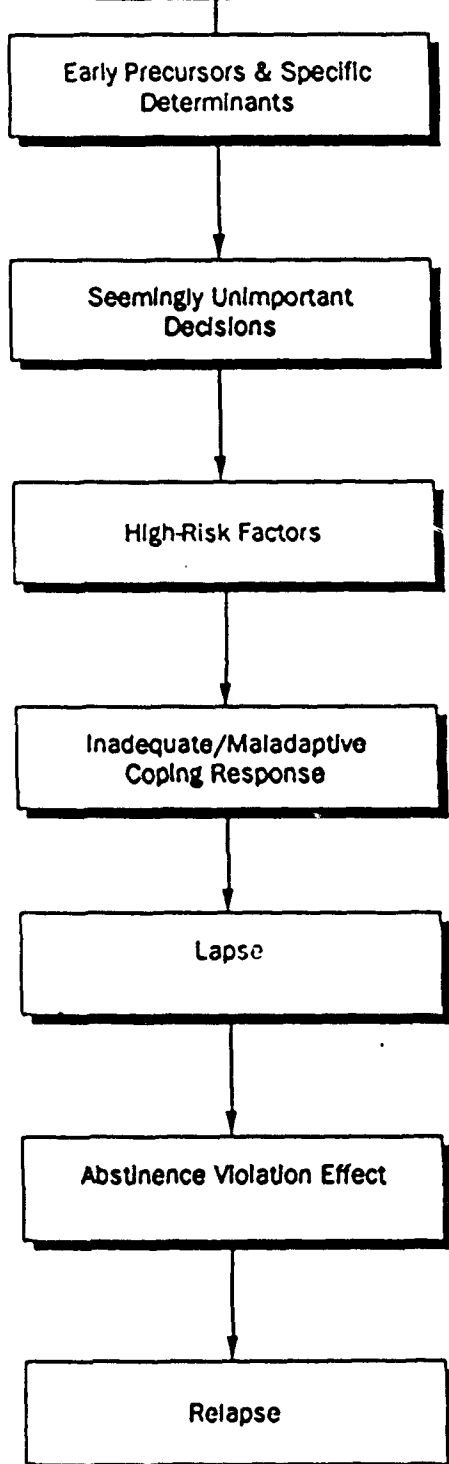


Seemingly Unimportant Decisions



Treatment Components

RELAPSE PROCESS



RELAPSE PREVENTION INTERVENTIONS

For Avoiding Lapses

Lifestyle Interventions

Relaxation training

Reeducation groups

Treatment of sexual dysfunction

Alteration of deviant sexual arousal pattern

Recognition of relapse precursors

Stimulus control procedures

Programmed coping responses

Escape strategies

Anger and stress management

Interpersonal skills enhancement

Avoidance procedures

Problem-solving and self-control skills

For Minimizing the Extent of Lapses

Coping with urges

Contracting

Lapse rehearsals

Reminder cards

Decision matrix

Cognitive restructuring

Maintenance manuals

RELAPSE PREVENTION GROUP PROCESS

STAGE ONE: HOMEWORK

GROUP MEMBERS ARE INSTRUCTED TO PREPARE A LIST OF THEIR OWN RISK FACTORS FOR THE NEXT GROUP SESSION.

STAGE TWO: RISK FACTORS

IN SEQUENCE, EACH GROUP MEMBER READS ALOUD HIS HIGHEST RISK FACTOR. GROUP MEMBERS DISCUSS EACH RISK FACTOR TO ENSURE UNDERSTANDING AND ASSIST DIFFERENTIATION. A GROUP CO-LEADER WRITES EACH RISK FACTOR ON A FLIPCHART. THIS PROCESS CONTINUES UNTIL EACH CLIENT'S LIST OF RISK FACTORS HAS BEEN EXHAUSTED.

RISK FACTORS FOR SEXUAL ABUSE

PEOPLE AS SEX OBJECTS
POOR COMMUNICATIONS
DEPRESSION
LACK OF EMPATHY
FEAR OF REJECTION
LOW SELF ESTEEM
RUSHING INTO RELATIONSHIPS
EMOTIONAL ISOLATION
DRUG ABUSE
NEGATIVE SELF STATEMENTS
UNEMPLOYMENT
UNEXPRESSED ANGER
DISHONESTY
KEEPING SECRETS

ROLE PLAYING
LONELINESS
DRINKING
PASSIVITY
OVERWORKING
NOT EXPRESSING FEELINGS
ABUSIVE SEXUAL FANTASIES
DISTRESS
MISREADING SOCIAL CUES
COMPARTMENTALIZATION
ENDING A RELATIONSHIP
LACK OF LEISURE TIME
FEAR OF REJECTION
BELIEVING YOU'RE CURED

RISK FACTORS FOR SEXUAL OFFENSES

PORNOGRAPHY USE
COERCING VICTIM WITH DRUGS
TAKING OFF WORK WITHOUT REASON
ALLOWING YOURSELF TO BE BORED
PICKING UP A HITCHHIKER
MASTURBATING TO ABUSIVE FANTASIES
OBTAINING ITEMS TO BIND VICTIMS
GOING TO AREA OF PROSTITUTION
DANCING WITH INTOXICATED WOMEN
TALKING ABOUT SEX WITH VICTIM

HITCHHIKING
ROADSIDE REST AREAS
NUDE SWIMMING AREAS
GOING TO PLAYGROUNDS
STARING AT CROTCHES
EMPLOYING POTENTIAL VICTIMS
STAYING IN KNOWN LAPSE
FEELING INFERIOR TO PARTNER
TOPLESS BARS/STRIP JOINTS
HANGING OUT AROUND RESTROOMS

Early Precursors to Sexual Aggression*

Precursor	Rapists (%) (N=64)	Pedophiles (%) (N=136)
Cognitive impairment (IQ < 80)	9	10
Divorce (more than 5 years before act)	14	15
Exposure to violent death of human or animal	22	2
Familial chaos	86	49
Late sexual experience (older than 25 at initial activity)	0	4
Limited education (< grade 9 completed)	44	26
Maternal absence/neglect	41	29
More than one prior sex offense	14	17
More than one known victim	30	60
Parental marital discord	59	45
Paternal absence/neglect	59	54
Physically abused as child	45	7
Pornography use (habitual)	14	33
Precocious sexuality (< 12 years at time of first act of penetration not considered abuse)	14	30
Prior arrest for nonsex offense	44	15
Sexual anxiety	39	58
Sexual dysfunction	11	11
Sexual victimization		
Prior to age 12	5	56
Between ages 12 and 18	11	6
Use of female prostitutes	30	8

*See Pithers, W. D., Buell, M.M., Kashima, K., Cumming, G.F., & Beal, L.S. (1987). *Precursors to sexual aggression*. Paper presented at the Association for the Behavioral Treatment of Sexual Abusers, Newport, OR. Also see Pithers, W.D., with Cumming, G., Beal, L., Young, W., & Turner, W. (1988). *Relapse prevention*. In B. K. Schwartz (Ed.), *A practitioner's guide to treating the incarcerated male sex offender*, pp. 123-125. Washington, D.C.: National Institute of Corrections.

Immediate Precursors to Sexual Aggression*

Precursor	Rapists (%) (N=64)	Pedophiles (%) (N=136)
Anger		
At event	3	3
Interpersonal conflict	3	4
Generalized, global	88	32
Anger towards women	77	26
Anxiety	27	46
Assertive skills deficit	42	23
Boredom	45	28
Cognitive distortions	72	65
Compulsive overworking	0	8
Depression	3	38
Deviant sexual fantasies	17	51
Disordered sexual arousal pattern	69	57
Divorce	2	2
Driving car alone without destination	17	1
Emotionally inhibited/overcontrolled	58	51
Interpersonal dependence	30	48
Low self-esteem	56	61
Low victim empathy	61	71
Opportunity (e.g., finding a hitchhiker)	58	19
Peer pressure	2	3
Personal loss	6	14
Personality disorder	61	35
Photography as new hobby	0	4
Physical illness	14	6
Planning of sex offense	28	73
Pornography use	2	7
Psychiatric hospitalization	0	7
Sexual knowledge deficit	45	52
Social anxiety	25	39
Social skills deficit	59	50
Substance use/abuse		
Alcohol	42	23
Other substances	14	7

*See Pithers, W. D., Buell, M.M., Kashima, K., Cumming, G.F., & Beal, L.S. (1987). *Precursors to sexual aggression*. Paper presented at the Association for the Behavioral Treatment of Sexual Abusers, Newport, OR. Also see Pithers, W.D., with Cumming, G., Beal, L., Young, W., & Turner, W. (1988). *Relapse prevention*. In B.K. Schwartz (Ed.), *A practitioner's guide to treating the incarcerated male sex offender*, pp. 123-125. Washington, D.C.: National Institute of Corrections.

AFFECT»FANTASY»COGNITIVE DISTORTION»PLANNING»DISINHIBITION»ACT

Common Sequence of Precursors to Relapses of Sex Offenders

RELAPSE PREVENTION GROUP PROCESS

STAGE TWO: HOMEWORK

GROUP MEMBERS ARE INSTRUCTED TO REVIEW THE LIST OF RISK FACTORS. EACH CLIENT IDENTIFIES THE FIVE FACTORS WHICH ARE MOST PROBLEMATIC TO HIM. THESE SHOULD BE THE FIVE FACTORS THAT HE ENCOUNTERS MOST FREQUENTLY OR WHICH HAVE THE GREATEST POWER.

STAGE THREE: MOST COMMON HIGH RISK FACTORS

EACH GROUP MEMBER LISTS HIS HIGHEST RISK FACTOR. AS EACH FACTOR IS LISTED, OTHER CLIENTS WHO HAVE RATED THAT RISK FACTOR AS ONE OF THEIR FIVE MOST PROBLEMATIC RAISE THEIR HANDS AND A COUNT IS TAKEN. THIS PROCESS ALLOWS THE GROUP TO IDENTIFY THE RISK FACTORS MOST COMMON TO THE ENTIRE GROUP.

RELAPSE PREVENTION GROUP PROCESS

STAGE FOUR: HOMEWORK

GROUP MEMBERS ARE REQUESTED TO IDENTIFY POTENTIAL COPING STRATEGIES FOR THE GROUP'S HIGHEST RISK FACTOR.

STAGE FIVE: BRAINSTORMING OF COPING STRATEGIES

GROUP MEMBERS ARE REQUESTED TO BRAINSTORM AS POTENTIAL COPING STRATEGIES FOR THE GROUP'S HIGHEST RISK FACTOR ARE SUGGESTED. NO CRITICISM OF SUGGESTED COPING STRATEGIES IS PERMITTED. THE PROCESS CONTINUES UNTIL SUGGESTIONS (OR GROUP CO-THERAPISTS) ARE EXHAUSTED.

STRATEGIES FOR COPING WITH REJECTION

CALL SOMEONE
ACCEPT LIMITATIONS
ACCEPT "NO" FOR AN ANSWER
ACCEPT DISAPPOINTMENT
RESPECT OTHER'S POSITION
ASK FOR CLARIFICATION
WRITE OUT FEELINGS
THINK OF OTHER'S FEELINGS
TAKE DEEP BREATHS
DON'T BLAME OR PASS JUDGMENT

BE AWARE OF DISTORTED THINKING
LOOK SOMEPLACE ELSE FOR ACCEPTANCE
DON'T PLAY ROLES
BE AWARE OF NEED TO CONTROL
EXPRESS ANGER APPROPRIATELY
REMEMBER SELF-WORTH
ACCEPT FEELINGS
THINK POSITIVE
ALLOW OTHERS THEIR SPACE

RELAPSE PREVENTION GROUP PROCESS

STAGE FIVE: HOMEWORK

EACH CLIENT IS REQUESTED TO ANALYZE THE POTENTIAL COPING RESPONSES BRAINSTORMED BY THE GROUP. COPING RESPONSES ARE TO BE RATED ON A SEVEN-POINT SCALE ALONG TWO DIMENSIONS: LIKELIHOOD OF SUCCESS AND ABILITY TO USE. EACH CLIENT SELECTS HIS FIVE OPTIMAL COPING STRATEGIES FOR PRESENTATION TO THE GROUP.

STAGE SIX: REVIEW OF OPTIMAL COPING STRATEGIES

EACH GROUP MEMBER PRESENTS HIS FIVE OPTIMAL COPING STRATEGIES TO THE GROUP. HIS OWN RATINGS OF THE LIKELY SUCCESS OF EACH STRATEGY AND HIS ABILITY TO USE EACH STRATEGY ARE DISCUSSED. GROUP MEMBERS CONFRONT UNREALISTIC RATINGS AND DISCUSS ALTERNATE COPING STRATEGIES.

RELAPSE PREVENTION GROUP PROCESS

STAGE SIX: HOMEWORK

EACH CLIENT IS REQUESTED TO PREPARE A REMINDER CARD FOR THE GROUP'S MOST COMMON HIGH RISK FACTOR. THE NAME OF THE HIGH RISK FACTOR IS WRITTEN ON ONE SIDE OF A 3"x5" INDEX CARD. THE FIVE MOST RELIABLE CUES AND THE FIVE OPTIMAL COPING STRATEGIES ARE WRITTEN ON THE OTHER SIDE. CLIENTS PREPARE TWO SETS OF INDEX CARDS: THEY KEEP ONE AND GIVE THE OTHER TO THE GROUP CO-THERAPISTS. CLIENTS ARE INSTRUCTED TO REVIEW THE CARDS SEVERAL TIMES EVERY DAY.

RELAPSE PREVENTION GROUP PROCESS

STAGE SEVEN: PROCESSING OF OTHER RISK FACTORS

CLIENTS REPEAT THE PROCESSING OF OTHER HIGH RISK FACTORS COMMON TO GROUP MEMBERS (I.E., IDENTIFICATION OF CUES, POTENTIAL COPING STRATEGIES, RATING OF POTENTIAL COPING STRATEGIES, AND PREPARATION OF REMINDER CARDS. THROUGHOUT THIS PERIOD, CLIENTS MAY BE QUIZZED ABOUT RISK FACTORS, CUES, AND COPING STRATEGIES BY CO-THERAPISTS OR OTHER GROUP MEMBERS.

STAGE EIGHT: TESTING PREPAREDNESS

WITHOUT WARNING, ANY CLIENT MAY BE REQUESTED TO ENGAGE IN A RELAPSE FANTASY. AT ANY POINT IN HIS FANTASIZED RELAPSE PROCESS, A CO-THERAPIST MAY INTERRUPT AND ASK THE CLIENT TO STATE HOW HE COULD COPE WITH THE IMAGINED RISK SITUATION. CLIENTS ARE PRESSURED TO RESPOND AS QUICKLY AS POSSIBLE. PROPOSED COPING RESPONSES THAT ARE UNREALISTIC ARE CONFRONTED.

RELAPSE PREVENTION GROUP PROCESS

STAGE NINE: ANALYSIS OF EFFECTIVENESS

THE CO-THERAPISTS ASK GROUP MEMBERS TO REPORT ANY RISK SITUATIONS THEY HAVE ENCOUNTERED AND TO DISCUSS HOW WELL THEY WERE ABLE TO COPE. IF GROUP MEMBERS ARE RELUCTANT TO SELF-REPORT ANY HIGH RISK SITUATIONS OR LAPSES, THEY ARE ASKED TO CONFRONT OTHER GROUP MEMBERS WHOM THEY HAVE OBSERVED ENGAGED IN RISK BEHAVIORS OR IN HIGH RISK SITUATIONS. THE GROUP ANALYZES THE RISK FACTOR, CUES, AND COPING RESPONSES AND MAKES SUGGESTIONS AS TO HOW THE OFFENDER MAY DEAL WITH THE SITUATION MORE EFFECTIVELY IN THE FUTURE.

STAGE TEN: INFORMING SUPERVISION NETWORK

CLIENTS ARE REQUIRED TO MEET WITH THEIR THERAPIST AND PROBATION OR PAROLE SUPERVISOR. CLIENTS DELINEATE THEIR RELAPSE PROCESS. THIS INFORMATION MUST ALSO BE PROVIDED TO PROSPECTIVE EMPLOYERS, COMPANIONS, ETC. ACCURACY OF INFORMATION IS CHECKED BY THE CORRECTIONAL SUPERVISOR.

RELAPSE PREVENTION GLOSSARY

ABSTINENCE: The decision to refrain from taking part in a self-prohibited behavior. For sex offenders, abstinence is marked by the absence of fantasies, thoughts, materials, and behaviors that are associated with their offense patterns.

ABSTINENCE VIOLATION EFFECT (AVE): A term used to describe a variety of changes in beliefs and behaviors that can result from engaging in a lapse. Among the components of the AVE are a sense one is weak-willed and unable to create personal change; an expectation that failure is unavoidable; and the Problem of Immediate Gratification. When sex offenders are not prepared to cope with the AVE, the likelihood of relapse increases. The AVE is experienced most strongly when clients believe that lapses should never occur.

ADAPTIVE COPING RESPONSE: A change in thoughts, feelings, or behaviors that effectively deals with a risk factor or lapse and reduces the likelihood of relapse. Adaptive coping responses may be either general or situationally specific.

General coping responses enhance the quality of life. These include anger and stress management, enhancement of interpersonal skills, lifestyle interventions, relaxation training, and training in problem-solving procedures.

Specific coping responses deal with lapses and identifiable risk factors. These include stimulus control, avoidance, escape, programmed coping strategies, cognitive restructuring to reduce the impact of the AVE, lapse contracts, reminder cards, and decision matrices.

COGNITIVE DISTORTION: A thinking error or rationalization that is used by sex offenders to justify abusive emotions and behaviors. In essence, these are self-generated excuses for taking part in one's relapse patterns.

DISINHIBITORS: Internal or external stimuli which decrease personal prohibitions against engaging in sex offenses. One example of an internal disinhibitor is a cognitive distortion ("That 8 year-old sure is leering at me."). Minimal substance use is one type of an external disinhibitor.

EXTERNAL SUPERVISORY DIMENSION (ESD): The aspect of relapse prevention that enhances the ability of probation/parole officers and significant others (e.g., employer, family, friends) to monitor a sex offender's offense precursors.

HIGH-RISK FACTORS: A set of internal stimuli or external circumstances that threaten a sex offenders self-control and thus increase the risk of lapse or relapse.

INTERNAL SELF-MANAGEMENT DIMENSION (ISD): The aspect of relapse prevention that allows a sex offender to better recognize and control offense precursors.

LAPSE: An emotion, fantasy, thought, or behavior that is part of an offender's relapse patterns. Lapses are not sex offenses but are precursors or risk factors for sex offenses.

LAPSE CONTRACT: A contract signed by the therapist (or probation/parole officer) and the offender that specifies the extent to which the offender is permitted to lapse. Effective lapse contracts include clauses that require offenders to delay engaging in the lapse, permit only one instance of the lapse, require immediate reporting of the lapse, and enact some penalty (e.g., donations to a rape crisis center).

MALADAPTIVE COPING RESPONSES: An apparent effort to deal with a risk factor or lapse that actually enables the sex offender to get closer to relapse. For example, an angry rapist who decides to take a drive in order to cool off might decide to pick up a female hitchhiker.

PRECURSORS: A general term used to encompass seemingly unimportant decisions (SUDs), maladaptive coping responses, risk factors, lapses, and the abstinence violation effect. Precursors are events that occur prior to a sex offense.

PROGRAMMED COPING RESPONSES: Pre-planned responses to deal with specific risk factors that a sex offender might reasonably expect to encounter in the future.

PROBLEM OF IMMEDIATE GRATIFICATION (PIG phenomenon): The PIG phenomenon is part of the Abstinence Violation Effect (AVE). It occurs when sex offenders selectively remember the positive sensations experienced during, or immediately after, past assaults. Recalling only the immediate positive sensations from past assaults increases the likelihood of another offense. The problem of immediate gratification is that the abusers forget about the negative consequences that generally are delayed (e.g., guilt, loss of family and friends, loss of employment, newspaper and television coverage of arrest and conviction, incarceration, parole, etc.). When abusers learn to counter the strength of the PIG phenomenon by focusing on the delayed negative effects of their acts (and the immediate and delayed harmful impacts on victims), the likelihood of relapse decreases.

RELAPSE: A sexual abusive behavior or sexual offense.

RELAPSE PREVENTION (RP): A process for enhancing emotional, cognitive, and behavioral self-management and external supervision of sex offenders.

SELF-DEPRECATATION: Belittling or putting down oneself.

SEEMINGLY UNIMPORTANT DECISIONS (SUDs): Decisions that seem to have little bearing on whether a lapse or relapse will occur, but which actually allow the offender to get closer to or further away from high-risk factors that increase the probability of another offense. A pedophile who decides to go Christmas shopping at a mall on a Saturday afternoon is making a Seemingly Unimportant Decision. In reality, the inevitable presence of children in the mall will allow the abuser to have placed himself in a high-risk factor where he may lapse or relapse.

STIMULUS CONTROL: A specific coping response that removes from an offender's daily environment all items associated with that person's relapse pattern. As an example, a pedophile who views child erotica to enhance sexual fantasies can remove all photographs and drawings of children from his home and office.

MALE SEXUAL VICTIMIZATION
A REVIEW OF CURRENT SOCIAL SCIENCE RESEARCH

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MALE SEXUAL VICTIMIZATION

A REVIEW OF CURRENT SOCIAL SCIENCE RESEARCH

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Until recently there has been little research information about child sexual abuse. The absence of data seems to be related to a number of different issues. However, as child sexual abuse of females has come to light and been the subject of research and investigation, so too are males beginning to reveal more about their sexual abuse and seek assistance. The purpose of this paper is to highlight trends in current social science literature on the sexual victimization of male children.

Most of the literature reviewed for this project was generated from medical, sociological and psychological data based computer searches. Research articles were selected for their recency and comprehensiveness. Literature reviews for this paper revealed a body of descriptive data, largely published in recent years and a few experimental research projects concerning related issues. The empirical research is descriptive at this stage and can be viewed as being on the "frontiers of knowledge". These descriptive findings when viewed in isolation seem confusing, but when viewed as a whole do illustrate some clear meaningful trends. Inconsistencies among studies largely seem related to the diverse group of populations sampled and differing definitions of sexual abuse.

Definitions of Abuse and Populations Sampled

The review of current research literature clearly revealed that differing definitions of sexual abuse have been employed among research projects. Definitions generally included a combination of two separate conceptual criteria, i.e. age difference of participants and the presence or absence of coercion. Age difference was commonly defined as 5 years or more between "victim" and "perpetrator", and was found to be fairly consistent from one project to another. Another consistency among the definitions was the presence of a coercive element. Some studies expanded the definition of coercion to include type of relationship, i.e. it was judged as abusive if the "perpetrator" was an authority figure or

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care giver to the "victim". How these criteria were combined however, varied among studies. The common inconsistency in definitions between research projects seemed to pivot on whether an activity was considered abusive if the necessary age difference of participants existed but the "victim" perceived the activity as desired.

Populations for various projects included a wide array of subjects; governmental registries of child abuse and neglect (Eckenrode, 1988; Pierce, 1985; Powers, 1988; Rosenthal, 1988), criminal settings (Burgess, 1988; Petrovich, 1984; Groth, 1979, 1986), educational settings (Condy, 1987; Hibbard, 1990), hospital settings (Dube, 1988; Hunter, 1987; Reinhart, 1987), and adult and child clinical samples (Bentovim, 1987; Carmen, 1984; Faller, 1989; McCormack, 1986).

Given just these two methodological issues, it should not be surprising to find the social science research literature evidencing discrepancies among studies.

Factors Particular to Males that affect Reporting Rates

If there is any one area that the various research projects unanimously agreed upon, it was that male child sexual abuse occurs at a higher rate than is evidenced through research study and that the incidence is difficult to even estimate.

When sociological and psychological factors particular to males are added to the prevalence equation it is a wonder that much research progress has been made at all. Socialization and stereotyping of male roles and norms serve to inhibit acknowledgement of sexual victimization as well as mask indicators that victimization may have occurred (Finkelhor, 1986; Groth 1985).

Independence and self-sufficiency are highly valued in traditional views of being male. Men, of course, are expected to fight their own battles. Turning to others for help or expressing vulnerability is often viewed as weakness. Revealing abuse or expressing sad or fearful feelings is often seen as unmanly. When dealing with adversity, males are expected to "take it like a man" often resulting in suppression or avoidance of painful thoughts and feelings.

Within the sexual realm, male on male sexual abuse is commonly viewed as a homosexual event where the victim's manhood has been compromised. When discussing risk of being sexually victimized, it is not uncommon to hear males claim that "somebody would be dead before that happened". Furthermore, if a male is exploited by a female, the action is often regarded by others as not being traumatic. Rather, the action maybe viewed as the male being "initiated" into manhood where he is valued as a "lucky guy or real stud".

Because males generally are allowed more unsupervised and

adventuresome activities than their female peers they may be more susceptible to entrapment and secrecy. If a male is already participating in a prohibited activity then becomes sexually victimized, he is not as likely to reveal the abuse because of his own participation in wrongdoing as well as concern that future freedoms might be curtailed.

Finally, these factors may combine to veil indications of sexual victimization. The threshold of social tolerance for the display of compulsive or indiscriminate sexual behavior is higher for males than for females. In many instances such behavior is also valued and viewed as evidence of sexual prowess.

GENERAL TRENDS OF FINDINGS

Despite the aforementioned problems of research of male sexual abuse victim facing the research consumer, meaningful trends emerge from the literature body as a whole. The strength of trends varies from project to project but is still evident. Trends that crystallized within this review were categorized into Prevalence of Victimization, Validation Rates of Victimization, Relational Context of Victimization, Victim age at Onset of Abuse, Nature of Sexual Interaction, and Victim Response of Problem Behavior.

Prevalence of Victimization

In the mid 1970's, experts in the field were reporting sexual victimization of males as an infrequent occurrence (Awad, 1976; Finkelhor, 1979; Stoller, 1974). However, there seemed to be hints from anecdotal research with sexual offenders (Groth, 1979) and adult victims (Fritz, 1981) that the numbers of sexually abused males coming into contact with professionals was more likely to be an artifact of under reporting rather than a low rate of occurrence.

Current studies indicate that sexual abuse among the general population of males seems to range from as little as 3% to as much as 16%. With a national sample of male higher education students Risin and Koss (1987) found a prevalence rate of about 7%, Fritz (1981) found a 5% rate among a similar population while Condy (1987) found a rate with college men to be about 16%. With a younger general population of 4000 students from grades 7 to 12, Hibbard (1990) found a rate of about 6%.

Moving to more specialized populations, The American Association for Protecting Children (Faller, 1987) research project found national statistics for male sexual victimization to be slightly less than 20%. This child protective services database is only tapped cases that involved abuse by a caretaker. When looking at prevalence in other specialized populations, it increases to

ranges from 30% to roughly 80%. In studying families referred for therapy related to sexual abuse, Bentovim (1987) discovered that about one quarter of the victims were males. McCormack (1986) in a study of runaways found a 38% prevalence rate of sexual abuse of males. With criminal offenders which excluded sexual crimes, Condy (1987), in researching exclusively sexual abuse perpetrated by females, found a rate of about 46% and with sexual offenders (only rapists) a rate of 59%. Eighty two percent of sexual offenders were found to have been child sexual abuse victims in a study by Groth (1986). Similar high rates in special populations have been noted by others (O'Brien, 1986; Knopp, 1982, 1986; Porter, 1986; Faller, 1989).

In summary, the research indicates that male sexual victimization with special populations, particularly with criminal offenders, sexual offenders and clinical samples is much higher than that of the general population.

Validation Rates of Victimization

Across several studies there seemed to be a trend of the victim's gender being associated with whether a case was judged to be valid or authentic. In the early 1980's Roland Summitt wrote, "while there is a capacity to believe that girls may be helpless victims of sexual abuse, there is almost universal repudiation of the boy victim". Unfortunately, this statement foreshadowed what current studies are now finding. Generally, sexual abuse reports of males were found to be less often substantiated, i.e. not authentic, than reports of females. Powers (1988) found a decrease in substantiation rates in cases of adolescent males but not with adolescent females. Eckenrode (1988) in a study investigating close to 800 sexual abuse reports found that overall, allegations were more often substantiated for female than male victims. Male cases that tended to be substantiated were with children under the age of ten.

Of the few experimental studies found in this review, most were related to attribution of victim blame and shed light on the phenomena of lower substantiation rates of cases involving male victims. Jackson (1983) studied attitudes of college students about incest. Subjects responded to a questionnaire which assessed possible effects of gender, physical abuse and sexual abuse upon attribution of blame in incest. Results indicated that four issues seemed related to attribution of blame: victim, offender, situational and societal factors. The most salient finding (and the only statistically significant effect) was that males blamed the incest victim more than did females. It should be kept in mind that the questionnaire used tapped attitudes regarding incest specifically. Though not clearly stated, it is likely that the subject identified or perceived the victim in the questionnaire as female. A more recent study (Broussard, 1988) of college students

attribution of responsibility to the perpetrator presented three different vignettes of sexual abuse of a 15-year-old victim. The victim's gender and response role, i.e. passive, encouraging and resisting, were varied. Results indicated that male respondents held the perpetrators of male victims less responsible than those of female victims. Female respondents viewed the perpetrator responsible for the abuse regardless of victim gender except in the role response of encouragement where all respondents held the male victim's perpetrators less responsible than the female's. Likewise, in studying medical students' attitudes, Eisenberg (1987) noted that males were less concerned with the effects of sexual abuse for male than female victims,

Women may tend to empathize more with victims (of either sex) than men, or men respondents may have felt that boys would probably have more control/involvement in the sexual activity than girls resulting in less harm from the experience (p.115).

These studies as a whole suggest that not all minors are equally viewed as innocent victims. Victim response, victim gender, and gender of the person attributing blame are likely to play a role in blame ascribed to the perpetrator. This would likely impact validation rates.

Relational Context of Victimization

Relationship patterns between male victim and victimizer are evident, but must be considered in light of other factors. These issues might be best understood as those which relate to "Intra and Extra Familial Relationships", "Solo and Multiple Victims", and "Solo and Co-Perpetrators".

Intra and Extra Familial Relationships:

Many studies have identified that boys are more likely to be sexually victimized outside the home than girls (DeJong, 1982; Dube, 1988; Ellerstien, 1980; Finkelhor, 1979, 1984; Groth, 1979, 1986; Rogers, 1984). A recent study with a slightly younger population revealed a similar trend. Reinhart (1987) investigated a population referred to a medical center for child sexual abuse examinations. This study's findings indicated slightly higher percentages of unrelated versus related perpetrators upon females (57% opposed to 43%) and males (62% to 38%). A notable exception to these findings, Faller (1989) found more intrafamilial abuse with male victims, 63%. An analysis of age of onset revealed those abused within the household, mean age of about 5 1/2 years, were younger than boys abused outside the family, mean age around 7 1/2 years. Dube (1988) found that while boys were still likely to be abused outside of the home, preschool children were more likely to

be victims of intrafamilial abuse as compared to school age children. This would support Faller's findings that younger male children were more vulnerable to abuse inside the home.

Apart from where victimization may occur, boys and girls both seem to be at higher risk in single parent and blended family households. Lower socioeconomic status, regardless of race, is also associated with increased risk of victimization (Condy, 1987; Faller, 1989).

Solo and Multiple Victims:

Another factor which complicates this issue is that boys were less likely than girls to be a "solo" victims. Perpetrators against boys were more likely to have multiple victims as opposed to perpetrators against girls (Faller, 1989; Finkelhor, 1984; Rogers & Terry, 1984). Research by Reinhart (1987) evidenced a different finding. This hospital setting findings may have been in a context where limited contact with the victim may have occurred or where the abuse may have been more invasive resulting in noticeable injuries and referral. In addition, the mean victim age range of 3 to 5 years with this sample was much younger than others. Faller's (1989) study found boys and girls equally likely to be one of several victims in intrafamilial abuse. However, outside the family, boys were more likely to be part of a multiple victim scenario. Simply put, there was a trend that boys tend to be abused by perpetrators who abuse others as well.

Solo and Co-Perpetrators:

The additional issue related to this complicated picture of relationship of male victim and perpetrator involves patterns of solo or co-perpetrators which is commonly categorized by studies as male only, female only, or male and female acting together. Studies consistently have found that most male victims are abused by male perpetrators acting alone (De Jong, 1982; Faller, 1989; Finkelhor, 1984; Finkelhor and Russell, 1984; Groth, 1979; Knopp, 1986; Mayer, 1983; Porter, 1986; Reinhart, 1987; Risin & Koss, 1987; Rogers & Terry, 1984). The trends are consistent although the actual proportions of percentages vary within the 3 perpetrator categories. Across the board, the smallest group of perpetrators appears to be females acting alone. Although males were most likely to be the perpetrator, Faller (1989) found boys to be 10 times more likely to be abused by a female than girls (Faller, 1989).

Risin and Koss (1987), whose study sampled sexual experiences of college men, a more general population, found a much higher proportion of female perpetrators acting alone than did other research studies. Their definition of abuse included consensual experiences if the necessary 5 year age difference was present. As

cited earlier, the Condy (1987) study, which exclusively researched heterosexual victimization of boys, reported finding high percentages of abuse by females among rapists, child molesters and non-sexual offender inmates. The mean age at the time of victimization for this sample was about 12.6 years old. Likewise, Petrovich and Templer (1984) found that close to 60% of convicted rapists reported sexual experiences with a female that met the 5 year age difference definition.

In summary, trends indicate that boys are most often abused by males. It is likely that this trend does not reflect more recent research regarding consensual experiences that meet the criteria of significant age difference and therefore may underestimate the amount of abuse perpetrated by females. Male perpetrators against boys are more likely to have multiple victims and the victimization tends to take place outside the family. Even though patterns suggest that male victims are more likely to be abused by someone outside of the home, this trend should also be cautiously interpreted in light of the victim's age, i.e. younger males may be more at risk for intra-familial abuse.

Victim Age at Onset of Abuse

Estimations of average age at onset of the abuse, or vulnerability to abuse, vary from study to study. There appear to be no clear findings regarding age at onset of abuse. This possibly related to the aforementioned problems with under-reporting, heterogenous sample groups across studies and substantiation patterns. A particularly peculiar finding was a very apparent absence of reports from male children around the ages of 8 - 10 years (Dube, 1988, Faller, 1989). Several studies identified boy victims as being younger than girl victims (De Jong, 1982; Ellerstein & Canavan, 1980; Faller, 1989; Finkelhor, 1984; Rogers & Terry, 1984). Other studies found boy victims to be older (Faller, 1989; Finkelhor, 1979). Some research projects even evidenced a bi-modal age distribution (DeJong, 1982; Eckenrode, 1988). When compared to patterns with female victims, Bentovim (1987) noted that the sexual abuse of boys tended to be initiated under the age of 12 years whereas the abuse of girls was initiated at any age throughout adolescence.

Nature of Sexual Interaction

Studies fairly consistently indicate that the nature of the sexual abuse against young males is more invasive than abuse perpetrated upon minor females (Bentovim, 1987; Dejong, 1982; Dube, 1988, Ellerstein, 1980; Kaufman, 1980).

Bentovim (1987), in a sample of 274 families referred to a sexual abuse treatment program, found that boys were abused at younger ages, more severely and for longer periods of time than

were girls. Over half of the sexually abused boys in that study reported anal intercourse. Likewise, Reinhart's (1987) medical center study found that acts against boys were more invasive with sodomy being frequently reported in older victims. Condy (1987), in researching heterosexual abuse, found that at least half of the abuse perpetrated by females involved intercourse.

Findings in this area are likely to be tainted by validation and reporting rates. Cases of boys presenting with physical evidence of sexual abuse are more likely to come to the attention of authorities because of the injuries and such cases are more likely to be seen as authentic. When coupled with the pattern that the validation rates for boy victims are lower than that for females, these findings are more likely to suggest that it is the more invasive cases which surface into the reporting system.

Victim Response: Problem behavior

Over the last several decades, there has been a well established body of research literature supporting the presence of long and short term problems associated with childhood victimization. For males specifically, there appears to be some evidence of greater risk for later social problem behaviors as opposed to emotional problems than female victims. Social problem behavior, as used in this instance, refers to elements of conduct disorder behavior as well as sexually inappropriate or deviant behavior.

Hibbard (1990) found that sexual abuse had a particularly negative impact on male victims when compared to physical abuse or neglect only. The negative effect of sexual abuse was exacerbated by concomitant physical abuse. Sexual abuse for males was associated with greater risk for willingness to engage in health-damaging behaviors. These behaviors were defined as use of cigarettes, drugs, sexual activity, arrest, running away, riding with a drunken driver, causing a pregnancy and school suspension. Female victims were found to be at greater emotional risk defined as aversive emotions such as sadness, suicidal ideation, and sleep related problems. This study confirmed earlier research work by Hibbard (1989) who noted that it "is consistent with the findings that more male adolescents are represented among sexually abused youth identified in police-based studies".

The presence of previous victimization in the lives of sexual offenders has been well documented in the literature. Reviewing this specific line of research is not within the scope of this paper. However, this topic does need to be addressed because of the tendency for some to draw direct cause-effect conclusions between being a victim and becoming a victimizer.

Seghorn (1987) found about a 60% rate of childhood

victimization among child molesters. What is particularly interesting about Seghorn's work is that the study also analyzed other associated family problems such as parental psychiatric history and presence of alcohol or drug abuse. The study suggests that when early sexual victimization did occur in the life of the sexual offender, it was associated with many other factors of family instability and chaos. The presence of family problems are commonly noted by professionals working with juvenile sexual offenders as well (Abel, 1982; Groth, 1979a, 1979b, 1986; Knopp, 1982; Ryan, 1987, 1989).

Perhaps the conclusion that can be drawn from the literature on this issue is that for males, sexual victimization may be likely to be associated with overt behavioral rather than emotional indicators. Also, adults with histories of childhood sexual abuse are more likely to have mental health problems than the general population. Among sexual offenders the previous victimization rate is quite high. The literature does not indicate, as some professionals would claim, that previous victimization places males at higher risk of becoming sexual offenders. Rather, it is more in keeping within the realm of current knowledge to simply conclude that those who are sexual offenders are likely to have previous victimization be a part of their experience.

DISCUSSION

From the review of literature, the mental health professional can safely conclude that boys are a vulnerable population for sexual victimization and some specific populations like sexual offenders report unusually high rates of child sexual abuse. It is evident that social scientists continue to struggle with an consistent definition of abuse which applies to males which does not seem to be the case with female victims. In addition, it is within reason to conclude that sociological and psychological factors may work to veil abuse and indications of abuse of the male victim. Attribution of victim blame and invasiveness of abuse appear to be salient factors in validation rates of male sexual abuse victims. Age appears to be associated with vulnerability to abuse in particular settings, with older boys being more at risk from extra-familial abuse. It seems that those who offend against boys are usually males who are likely to have multiple victims. In the few instances where the perpetrator is female, boys are at a greater risk for being victimized. Still little is known about the possible short and long term effects of sexual victimization of boys. Early indications in the literature suggest that male victimization is associated with risk for engaging in problem behaviors.

IMPLICATIONS

Because the literature suggests differing trends and circumstances related to a sexual abuse victim's gender, it is important that mental health professionals be aware of these issues not only our obvious application to differences in assessment or treatment but also to our own underlying biases and attitudes. Longitudinal studies tracking possible short term and long term problems of young male victims through their development into adulthood are needed as well as more research regarding therapeutic issues specifically related to the male victim. Addressing previous victimization for special populations appears to be a real problem warranting swift and responsible attention from the mental health community. Hopefully, as more research work is conducted, mental health professionals will move beyond the current findings supporting that this problem does indeed exist and discover how to protect and assess and treat the male victim of sexual abuse.

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THE OFFENDER'S PROJECT MODEL OF OUTPATIENT
TREATMENT OF SEXUAL OFFENDERS

BY

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In July, 1986, Family Guidance Center/CMHC began its Sex-Offender Project, in conjunction with the local probation office. This allowed for outpatient treatment for offenders, complying with the new Missouri statutes, 566.140, 589.040, and 561.120. These statutes mandate outpatient treatment for sex offenders convicted, but not incarcerated (on probation or parole). This would equate with the treatment received by those incarcerated, and treated in the Mo. Sex Offenders' Project (MOSOP). In order to establish equitable criterion, the Family Guidance Project (FGSOP) was designed after MOSOP. The challenge was to design it in a way that allowed for the offenders to experience the intensity of treatment, but allow for living, working, etc. "In-house" treatment can be daily, very intense, and having the offenders living under very controlled conditions. Out-patient treatment must be intense enough for generalization, but account for dangerousness to self and others, and activities of daily self-care.

MOSOP (in-house) is directly based on Stanton Samenow's work at St. Elizabeth's Hospital, Washington, D.C. FGSOP is formatted directly on MOSOP, extrapolating for outpatient conditions. While the cognitive-behavioral model is followed as defined in MOSOP, two considerations have developed over the growth of the project:

1). Family-of-origin "shame" must be addressed in working with both intra- and inter-personal phenomena, and 2). Networking and combined community resources must be used to bring both behavior and cognition under therapeutic control. The issues between group-meetings can be as critical as issues within group-meetings. We have also found that the emotional and spiritual side of the offender must be accommodated, as emotional reactivity can be disastrous on an out-patient program. As a comprehensive mental health center, we have also enjoyed adequate support and "back-up" from within (i.e., psychiatric, psychological testing, family-work, and 24-hr. emergency services).

FGSOP has been operating for close to six years, and a table can be found at the end of this paper that reports data surveyed at the end of five and one-half years (July-1986---Dec.-1991). We, of course, claim no empiricism with this type of data, as it is statistical reporting, only. It is based on reported data, and this is always subject to error. On the other hand, with a small "N", and the anecdotal quality of a smaller, well-networked community, it is considered fairly accurate.

As one can readily see, direct crimes against children comprise about 80% of the offenders. The remaining crimes usually include a "child-like" victim, i.e., one with less noticeable power than the perpetrator. This correlates

quite directly with family-systems data, shame-data, and the "all-but impossible task", to individuate from shame-based families of origin. These inter-generational systems seem to flourish, producing people with blurred boundaries, both personal and inter-generational, little ability or history of interpersonal bonding, no empathy for others, and a statement to the world that says, "I will do what I need for me, regard-less what it costs you." Unfortunately, they usually don't know what their needs are, and are in a constant state of blame and projective identification. Thus, shame, not self-esteem, is their base, and they must constantly seek external gratification (and at the "externals" expense!). Mental health professionals usually see these individuals in the developmental continuum of the personality disorder, usually "cluster-B". Under DSM-III, R, there are labels like "Anti-social", "Border-line", "Narcissistic", and the like. Family therapists have labels like "Autocratic", "people from over-adequate/under-adequate parental marriages", "Type-B", and the like. MOSOP at one time even formulated the diagnosis of "Personality disorder, criminal type". This seems to come closest to this writer's conclusions.

There is an "invisible line" that most of our populace will not cross---that limit we see, that curtails even certain delicious fantasies. The content of thinking

has been researched and is continually seen as NOT an initiator of behavior IN MOST PEOPLE! There are other variables involved in certain populations that allow or cause them to act upon "think, alone". This has been shown in untreated, advanced alcoholics, "criminal-types" (as defined by Samenow), and sex-offenders, defined both by MOSOP and FGSOP. Thus, research and theory from all three areas has been used in formulating and refining an out-patient project for this population.

With some variation, we have found the offenders to have come from the "over-adequate, under-adequate" parental marriages that traditionally produce "character disorders", or more currently referred to as personality disorders, Axis-II. They have crossed racial, social-class, and educational boundaries (ironically--probably culturally, we have had only one percent female---one woman, ninety-seven men!). We have seen families rampant with social issues (i.e., divorce, single-parent, unemployment, etc.). There has been little history of mental illness, and the offenders are within general population norms for their own victimization. While alcoholism as a secondary diagnosis has consistently run about thirty percent, inter-generational familial alcoholism has been all but universal. Little differentiates this population from other groups seeking services at our Center (voluntarily or

involuntarily). The following "themes", however, keep emerging: 1-There are blurred boundaries; 2-immediate need-gratification, at another's expense; 3-projection and projective-identification as a primitive mode of relating to their environment; 4-denial of dependency needs---projected; 5-no concept of a power outside and/or greater than self--even true of "church-going, Christian" offenders; This leads directly to the feeling/belief that "I am the center of the universe!"; 6-feelings/beliefs of entitlement; and 7-a belief that their opinion is real, while others are only opinions--leading them to never question their PERCEPTION of an idea.

It appears that this "shame-base" precludes guilt or empathy. There is no concept that their behavior may hurt another, or the depth of the devastation. When accused of a trespass, they tend to focus on the tone of the accuser, and the "accuracy of his/her facts", where any loopholes may be, and how can one escape any negative consequences. It is a "whole 'nother story", however, if the offender is transgressed! Total justice and retribution is demanded!

This "shame-base" also keeps the offender separate and apart. He/she cannot "peer" with anyone, as others are seen as not as good as, or better, and threatening. Thus, at least for the male, there is little discrimination between

women and children, both being seen as targets for needs. It appears to be in this area that the offender can oscillate comfortably from generation to generation, seemingly non-discriminatorily. It is as if to say "...all externals are fair game!". There is no inherent sense of self, no resolute limits or values. Shame precludes any internal kinetic feedback to use to limit one's behavior. This does NOT mean to say it relieves them of any fault or responsibility-that will be reviewed in the treatment section. Offenders have choices; their choices are just not universally approvable to the normative population.

This "shame-base" seems to preclude any goal-directed, value system. They purport generic values of God, America, and apple pie, but fail to use them to guide their decision-making, nor behavioral choices. It seems that they form a "negative spirituality". A "Good day" is one when nothing bad has happened, yet! Power and control are the concepts to be "reckoned with", and all of life is perceived through this filter. Even sex is a tool, a task, a bargaining format---not a bio-emotional sharing between peers. Although many of the offenders have married, sex and sexual relationships are seen as something to use, to pleasure the self, and not as a physical expression of wholistic love-making. Thus, an offender believes it to be his "right" to "take sex" from a victim, since he is able

to, and the victim is there! The projected belief that "the victim is at fault, or he/she wouldn't have been there!", serves as an ego-syntonic belief that perpetuates their reality. This, along with a long-carried sense of entitlement, allows them to continue aberrant behavior, and still carry a decent picture of self! Unfortunately for any spouse or family member at hand, they are "natural targets", since they are "owned" by the offender!

While the afore-mentioned characteristics of the offender is certainly not all-inclusive, we believe it is sufficient to qualify this individual as a candidate for "relapse-prevention". While this term was originally used in disease-based pathology, it is certainly applicable to the unacceptable choices and behaviors of the sex offender. When "transposing" concepts, however, there are certain inherent danger points-and we experienced them early in the project! It is wonderful that different fields are now sharing their tools. Our current project draws from the cognitive-behavioral of MOSOP, family systems (primarily the work of Murray Bowen and Salvador Minnuchin), the language and processes of the "12-STEP" programs, social-learning, and a cognitive form of object-relations theory. It has been an on-going struggle to arrive at a balance, however. Many of the basics are related in a very intricate manner, and the concepts are quite complex. When applying such an

interface to a group that is known to: a) think very concretely, and b) spot and use any and all discrepancies, the "lines are drawn!". A case in point is "powerlessness", so basic to disease-based recovery and relapse-prevention.

Offenders would immediately add this to their already-growing "excuse-pile", and away they go! Ordinarily, this concept is difficult for the normal population, so offenders "feel right at home". Alcoholism-treaters can differentiate between "lip-service to the 12-steps", and the few who actually seem to "surrender", and inculcate them into their very sense of being. A "transformation" is noted here, and is discernible to the trained eye. It is closely comparable to the "re-birthing" concept (a "death"--then "resurrection"), seen in the major world religions. Ordinarily, at least two to three major life areas are observably changed.

FGSOP has also had to integrate a model that demands "self-responsibility" with court-ordered attendance. We acknowledge, of course, that without this, we would have no attendance! There will always be clinical/administrative trade-offs!

It appears that the "Healing" concepts of the disease/relapse model are directly applicable to offender-behavior, whether one believes there is a "something" to heal, or not. An example would be the first

three of the "12-steps". They were originally conceived to be applied to disease-based phenomena, and there are reams of efficacy studies to support their use. Currently, however, they are being applied to addiction (cigarettes), addictive-like behavior (gambling), and the like. The "jury isn't in, yet", as to outcome. As a CMHC that has long-treated alcoholism, however, we have a "working hypothesis": It's not whether the steps are applicable, or not, but whether or not we can get an offender to use them! It has long been held that alcoholics have to "reach their bottom", in order to allow for "surrender". Offenders rarely come to our project at that point in life---although one would think that court, jail, and prison would "address" that! The projective stance is usually still in tact, and that is far more primitive, and more difficult to penetrate than the disease-based denial. For the group of offenders that are also diagnosed alcoholic, we believe that the disease must be considered primary, and treatment successful if we are to have a chance at offender-behavior. It has been our experience that, once treated successfully for alcoholism, an offender is more amenable to treatment for offender behavior. The "successful outcomes" for the men (no female offender/alcoholic, to date) dually diagnosed, it seems to lead to two skews; A.) The two were separate, though sometimes over-lapping, problems, and B.)

offender-behavior is not seen when recovery is evident; the two are incompatible. We are not speaking of offender-responsibility, as recovery demands responsible ownership and restitution for any and all transgressions, as a condition of recovery.

It has become obvious to our staff that relapse-prevention will be a concept foreign to the offender, and the probation/parole officer will be a "significant other" in the offender's life, if there is any chance for success. At one time, mental health professionals were taught that a client/patient must want to get well, if they were to do so. Offenders want only to be left alone! The courts pick on them. The family picks on them. Now, a "shrink" is going to pick on them, and probably "mess with their heads" so bad that they may do something terrible! What a nice stage to walk on! It became obvious quite early that a few "rules to live by" would be necessary:

- 1.All information flows freely, both ways, between FGSOP and Probation. WE ARE ONE!
- 2.All goals are mutual and reciprocal.
- 3.No more rules in this area!

Obviously, the project is a veritable breeding ground for re-enactment---probation and Family Guidance become Mom and DAD, and the dysfunctional family reincarnates! It is a

constant struggle to keep the probation/mental health staff in the adult generation, as these "children" are masters of triangulation. During the first two years of the project, staffing patterns allowed for a female probation officer and male therapist to co-lead the group. Luckily, that gave us the "practice" we needed to become "adult-parents", and now can still "run the family" without both being present (we meet VERY regularly, however!).

The offenders are sent to the project directly from the probation officer (after court, if probation, and upon prison release, if parole), and are evaluated by the therapist who runs the group. Further evaluation, if needed, can be requested by the therapist, the probation officer, or the offender. Other services are available, and can be initiated by the same three sources. Some need family therapy, marital work, referral-resources, medical. After the initial evaluation and treatment plan, cases are reviewed minimally every three months. They are also subject to the Center's Quality Assurance procedures.

At this time, we are seeing the program in two stages: 1) major clinical portion--1 to 2 years; 2) relapse-prevention---until completion of obligation. During the first year, ordinarily, most ancillary work is addressed. This may include any psychiatric and/or substance-abuse issues, marital-family work, and referral to

support agencies. Many have lost their jobs, so Division of Vocational Rehabilitation is a primary resource, along with our own Work, Inc. program. Psycho-educational programs are available, as are more traditional CMHC services. The offender is required to pay a small fee for the Offender-project, but other services are on the Center's sliding scale. This fits with the concept of self-responsibility for the offender-behavior, but does not discriminate for traditional mental health services, available to all on a sliding scale. The project meets every Saturday for two hours, and the offender sees his/her officer at least on a monthly basis.

The original project began with a simple goal, supported by three simple objectives: GOAL: To offer designated offenders (on probation or parole) a modality to preclude repetition of said offense, and the like, that brought them to the courts.

OBJECTIVE: To assist offenders in using socially-acceptable means for need-gratification.

OBJECTIVE: To assist in their adapting to using mainstream resources to achieve and maintain psychosocial stability.

OBJECTIVE: To teach "extra-familial peer-bonding" as final closure for relapse-prevention.

Five and one-half years later, we would still purport this to be our goal and objectives, but have a little more realistic sense about realizing our goals. An example would be the page of data submitted at the end of this paper. We are able to offer some gross generalizations about some of the data: We have more men than women; we have more non-alcoholic than alcoholic offenders; We TEND to treat non-violent offenders; This type of data, and similar demographic type has been fairly consistent over time. What we would hesitate to generalize from would be what could be termed "successes". While this looks nice on paper, that is all it is...nice paper! "NO NEW OFFENSES, SEXUAL, OR OTHERWISE", really means none that we could find out about, or track through the regular channels. What the 78 discharged offenders did after leaving us is really anyone's guess. AT most, and with the best follow-up, we only have a small group, and only tracked from one to five years. They may have offended and we cannot access the data, or they may NEXT year!

What we do know, however, is quite clear: We now know that there are more questions than answers. There are more "forces" against recovery and change, and FOR relapse than we would have surmised. There may be some social/cultural questions that need to be addressed before we can reach new heights in the treatment of offenders.

There are, however, some interesting questions arising, especially since we are combining the data from family systems, alcoholism, holistic medicine, and the various mental health theories. For example...Is it possible to experience total and lasting recovery, without a "surrender and turning over to a Higher Power"-----some "leap of faith", so to speak? More and more data from alcoholism and mental illness are pointing to these and similar questions. It will be interesting to see "funding patterns that honor the separation of church and state", if research continues to blend and obscure the difference between Theology and Psychology! Let the debates begin!

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DATA-BASE---DEC. 31, 1991

TOTAL PROGRAM	DISCHARGED
N=98	N=78
No new S-offenses=94(96%)	74(95%)
<u>NO</u> new offenses=79(81%)	58(74%)
Revoked=19(19%)	19(24%)
Tech. offense=12(12%)	12(15%)
New S-offenses=4(4%)	4(5%)
New, Non- S-offenses=3(3%)	3(4%)
Other(1-died)=1(1%)	1(1%)

Male=97(99%)
 Female=1(1%)
 Alcoholic(Dx)=30.6%
 Employed=67%
 Unemployed=20%
 Handicapped=9%
 Retired=4%
 Married=37%
 Divorced=30%
 single=30%
 widowed=2%
 "Living with"=2%

OFFENSES:

Incest-----37.8%
 (Bio---19.4%)
 (step--18.4%)
 Pedophile-29.6%
 Rape-----9.2%
 Stat.rape-12.2%
 Indec.Exp.-4.1%
 Harras'mt.-7%

CRIMES AGAINST
 CHILDREN=79.6%

BIO-SKETCH

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The Project has grown under the supervision of Don Christensen, A.C.S.W., L.C.S.W., Director of Outpatient Psychiatric Services.

**A COMMUNITY SUPERVISION PLAN
FOR SEX OFFENDERS USING
DIFFERENTIAL MODELS OF RELAPSE PREVENTION**

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The role of treatment in reducing sex offenders' rate of recidivism has been frequently explored. Results are understandably mixed, principally due to two factors: a) the well-documented phenomena of underreporting of sex crimes and b) methodology differences across the studies. Significant factors include length of follow-up, measure of recidivism (for instance, sex offenses only vs. any new criminal offense), and sample size. Also of relevance is the fact that those offenders selected for treatment may differ at the outset from those not provided with treatment. This would logically bias any comparisons between the two groups. Furby, Weinrott, and Blackshaw (1989) and Quinsey (1984) concluded that any trends noted in how treatment impacts recidivism should be viewed cautiously.

Despite such findings, the need to continue creating and implementing effective means of reducing sex offender recidivism cannot be underemphasized. It is patently obvious that incarceration alone does not produce substantial decreases in any form of criminality. Robert Freeman-Longo (1986) estimates that 80% of all types of sex offenders released from prison go on to commit new offenses. Given the problem of continually burgeoning prison populations, it is less and less likely that sex offenders will begin receiving sentences that keep them incarcerated forever.

In her book Retraining Adult Sex Offenses (1984), Fay Honey Knopp reports that most sex offender treatment specialists believe that this population can be treated with success if the evaluation and treatment are thorough and are competently administered. Treatment programs which have established reputations for offering quality treatment are characterized by their high degree of structure and intensity. Also of note is their emphasis on training offenders that their deviant behavior is a life-long problem and must be addressed on an ongoing basis.

Knopp cites specific goals that are consistent across those programs which offer the

most comprehensive range of rehabilitation. Goals of the treatment phase generally include that: 1) the offender accepts accountability; 2) he recognizes the cognitive, behavioral, emotional and environmental events preceding his acting-out; and 3) he learns new attitudes and behaviors, including specific skills which allow him to interact responsibly in society.

It can reasonably be argued that even short-term reductions in the number of sexual assault incidents that an individual perpetuates can be cost-effective in monetary terms and in terms of the emotional and physical costs to the victims. Potential victims are spared during any period in which an offender refrains from sexually assaultive behavior. Unfortunately, many communities lack programs which offer the necessary degree of structure, control and intensity. Most sex offenders are returned to society or remain in it without any attempt made to provide a thorough course of rehabilitation. Sex offender treatment is not intended as a means of offering more humane or less punitive methods of dealing with this population. Rather, it is in response to the harsh reality that the vast majority of them who are caught will at some point in their lives have the opportunity to reoffend in our communities, and that in all likelihood the seriousness of acts they commit will escalate. Clearly, the most opportune time to deter this from occurring is when the offender is under the control of the criminal justice system. This may be while he is in the community or when his return to it is impending.

Probation and parole officers assigned the task of supervising sex offenders are routinely frustrated in their efforts to stipulate treatment for their clients, due to the scarcity of adequate resources. Those who attempt to offer such services themselves may be stymied by the fact that they are not trained as mental health professionals and the roles of counselor and disciplinarian appear to be at odds with one another.

The position of this paper is that probation and parole officers can and should play an

integral part in the treatment process of sex offenders and that this role need not create a conflict with their traditional role. We maintain that their involvement in this process complements and augments their supervision role.

Green (1988) notes that in the field of community supervision there is an increasing tendency toward sex offender specialization and more active and diverse methods of intervention with these clients. Clearly, knowledge of those concepts utilized in sex offender therapy enable the officers to formulate supervision plans consistent with therapy goals and provide them a framework in which to confront client problems.

Pithers, Marques, Gibat and Marlatt (1983) developed an Internal Self-Management Dimension of Relapse Prevention as a maintenance model to assist sex offenders in achieving self-efficacy. Using the model, offenders identify the sequence of thought, feeling and behavioral events that weaken their resistance and increase their chances of reoffending. Avoidance of high-risk situations and training in decision-making strategies and other coping skills are proposed as means of interrupting the chain of events and thus deterring new offense behavior. A complementary model, the External, Supervision Dimension of Relapse Prevention (Pithers, Kashima, Cumming, Beal and Buell, 1987, 1988) offers a detailed structure in which this model can be reinforced and in which mental health professionals and community supervision officers can form a collaborative relationship.

As an extension of their role in the External, Supervisory Dimension, probation and parole officers are becoming increasingly involved in the treatment process. They are faced with the challenging task of developing creative methods of intervention that are time and cost-efficient and are within the boundaries of their official duties.

This paper offers a model of a six-month program of orientation classes and problem-solving sessions aimed at teaching offenders to recognize their sexual abuse cycles and

preventing relapse. In this plan, probation and parole officers function as group leaders. The Internal, Self-Management Dimension of the Pithers model provides the basic structure for imparting an understanding of how relapse occurs.

The training course ideally should be required as an adjunct to specialized sex offender treatment the client is undergoing. However, recognizing that such services are not always readily available to all offenders, the training courses may also be applied to fit the needs of the following groups, as well as those actively in treatment: 1) offenders returning to the community after receiving sex offender treatment in prison who are in need of follow-up and assistance in making the transition back into society, 2) offenders undergoing therapy which is not specialized for sex offenders, and 3) offenders for whom there are no appropriate services available. Granted, the latter is the least ideal scenario but also is an all too frequent one.

This program is not intended to expedite sex offenders' return to the community from prison or as an alternative to incarceration. Rather, it is intended as a means of filling some of the abundant gaps in sex offender services and as a starting point in creating effective community networks in this field. In reference to the latter, we believe that through implementation of projects such as these, probation and parole officers can draw mental health professionals into closer involvement in the field of sex offender treatment and that the gains will be mutual.

We recommend methods for implementing this training and a structure in which to provide it. Included in this structure are differential forms of applying the Relapse Prevention model, based on three identified typologies of sex offenders.

Target Population

All sex offenders assigned to community supervision should be stipulated by the

supervising officer to take part in the six-month training sessions. Participants are thus not to be selected based on their amenability to treatment or the predicted degree of their success in meeting the terms of supervision. In fact, those seen as most suitable for therapy services are generally the least in need of projects such as this, as they are most apt to be accepted by residential and other community services which are in existence, or by private clinicians. The proposed project virtually assures that all sex offenders whose sentence structure includes a period of community supervision will be offered an opportunity to: a) learn about the dynamics of sex offending, b) develop methods to enhance self-control, c) receive education on how therapy can be beneficial, and d) learn that it is not only possible but desirable to live a law-abiding life.

Typologies

Essentially, all participants should receive the same course and the same general life issues will be examined. However, recognizing that there are differences among sex offenders in terms of their levels of intellectual functioning, criminal histories, and styles of offending, among a host of other factors, we recommend tailoring the Pithers model to fit two typologies not traditionally accepted into sex offender therapy programs. These are: 1) the low-functioning offender, and 2) the sociopathic offender. While all offender types have similar treatment needs, to some extent their particular styles of irresponsibility merit different treatment plans. Even in group therapy where all members of a group address the same issues, differential focus is given and the approach varies, depending on the participant's pre-assault and assault cycles, other critical life problems (i.e. substance abuse, marital difficulties) and his ability to comprehend and integrate the concepts of therapy.

One of the principal considerations in implementing any form of treatment is predictability or the ability to positively impact outcome. Although some specific interpersonal

variables that may lead to sexual assault have been isolated, much improvement in this area is still needed to significantly effect sex offender treatment.

Various criteria have been used to develop taxonomies among sex offenders. The resulting profile types have been used as tools to identify risk factors and predict recidivism and thus have occasionally played a role in the decision-making process used by the courts in sentencing these perpetrators. More commonly, though, researchers have sought to identify clusters of distinguishing factors among this population with the aim of enhancing treatment efforts.

Examination of offense dynamics often reveals characteristics of the perpetrator and possibly even evidence of motivating factors. Amir (1971) described three types of rapists: 1) those whose offenses reflect personality aberrations and which have no particular role significance, 2) those whose offenses are supportive of their perceived role as males in the youth culture and whose principal motives are sexual, and 3) those whose offenses are role-expressive and are not premised on sexual drive but rather on the context in which they occur.

Nicholas Groth (1979) identified four subtypes among rapists and two-subtypes of pedophiles (Groth, Hobson and Gary, 1982). Critical features that delineate these sub-types involve the offender's style of approaching and interacting with the victim, antecedent life events, and emotional states dominating the pre-assault and assault stages.

In their examination of male sex offenders, relying on cluster analysis to produce subtypes, Rosenberg and Knight (1988) found nine subtypes which they deemed to be of clinical significance. They used five dimensions, all related to areas of irresponsibility in the offender's life. Interestingly, Rosenberg and Knight found that while rapists and child molesters did form some distinct clusters, other clusters had mixed offense types. The authors concluded that victim age/offense type should not be a preemptory consideration in typology

development.

Strangman and McDonald-Doren (1986) proposed three subtypes: sociopathic, calculating types whose offenders tend to escalate in seriousness, less criminally-oriented types whose offenses may be linked to inability to cope with stress and/or substance abuse, and those types who are impulsive, immature and perhaps mentally or socially retarded. As did Rosenberg and Knight in their 1988 study, McDonald-Doren and Strangman placed less emphasis on how existing sex offender theories might dictate classification and more on identifying shared characteristics in lifestyles and life-management issues.

While we recognize that classification of offenders according to psychodynamic and motivational factors may be pertinent therapeutically, for purposes of educating and training the offender, it is more practical to consider his level of intellectual and social functioning, responsiveness to structure and intervention efforts, and interpersonal style.

Within this framework of this project is the resolve to address the clients' problems in accordance with their particular needs and deficiencies. Meeting the offender at his or her level of sophistication, intellectual ability, and interpersonal style is essential to the effectiveness of treatment. The plan offered here is an adjunct to treatment that will ultimately empower the offender to effectively problem-solve and address long and short-term precursors to sexual assault. The major difference employed in this project is the classifying of sexual offenders to isolate variables negatively effecting a relapse prevention plan. The Relapse Prevention training model with sexual offender is applied to these typologies: Type A, Type B, and Type C.

Type A

These individuals are generally below average intelligence. They may be of average intelligence but present a very passive, dependent interpersonal style. These are individuals that generally present themselves as inadequate or that are viewed as flawed with regard to

interpersonal style. They may be illiterate or mentally retarded.

Their prognosis for successful treatment has traditionally been extremely limited. Oftentimes these individuals are found Not Guilty by Reason of Insanity or Incompetent to Stand Trial due to limitations or the images they project. These individuals lack problem-solving skills, interpersonal skills, and show poor ability in coping with the normal activities of life. The group leader must be able to relate to their needs at their level of understanding and provide skills training that will assist them in assimilating therapy.

Considerable patience and allowance for learning at different rates within the group setting should be maintained. If it necessitates repetition of particular sessions in order to insure that Type A participants' understand and are demonstrating knowledge of relapse prevention terminology, then that scheme should be employed. What has not worked for these type of individuals is apathy and others taking responsibility. Type A individuals can and should be held accountable and responsible for their sexual offenses. Seriously addressing personal deficits can facilitate positive change.

Type B

These individuals function intellectually from average to superior intelligence. Their interpersonal style is characterized by passive aggression. They typically have no criminal history other than sex offenses and have a very stable employment history. These individuals may also display a stable marital relationship and appropriate interpersonal relationships superficially.

One of the major deterrents to successful treatment with these individuals is their manipulateness due to level of intelligence. Many occupations are represented in this group, including professionals with college education and possibly advanced degrees. In therapy, these individuals maintain a posture of cognitive dissonance and utilize defense mechanisms

to rationalize offenses.

The main reason to group them with similar individuals is to address the problems presented with individuals with the same strengths formally focused toward the same end. Problem-solving capabilities within this classification are limitless. The interaction between this classification and their supervising field officers should prove reciprocally insightful for trainer and offender while implementing the relapse prevention model.

Type C

These offenders generally function at an average range of intelligence. They may deviate to just below average or slightly above average intelligence. They generally have criminal histories and possess strong antisocial components to their personality. This classification's major impasse to treatment is their lack of empathy and their potential for violent acts.

These individuals, when grouped with other classifications, negatively impact therapy and learning. They have potential to incorporate the Relapse Prevention model due to their ability to discern intent and overtly displayed variables in their assault cycles. There are aggressive and narcissistic components to their personality along with a general disregard for the plight of others.

Grouping these individuals together may reinforce criminal thinking but will ultimately reinforce a groupthink that can be very effective. The Relapse Prevention model should be utilized with other areas of irresponsibility in the Type C offenders' lives as well as sexual assault behavior.

Training Sessions: Method, Content and Structure

The proposed schedule of training is one two-hour session weekly over a period of six months. The group meetings should not replace the regular stipulated contacts with

probationers and parolees.

All participants must be required to keep daily journals in which they report thoughts, feelings, and behaviors they experience in regard to problems. All unresolved problems are expected to be disclosed to the group. If the participant fails to do so, the group leader should bring the issue to the group's attention.

Problem-Solving

The sessions leader will find it beneficial to introduce the training with an overview of purpose, requirements and goals. It is necessary to emphasize the distinction between therapy and this program to which they have been assigned. Human nature should be explained in terms of a cognitive behavioral model. It is necessary to impart to participants the philosophy of this program in regard to sex offenders and sex offenses. Basically, the following points must be covered: 1) human nature is influenced by environmental and heredity factors, but ultimately people are the way they are because of the choices they make; 2) sex offending results from a flawed set of ideas and attitudes the offender has about himself and others and that these flaws or fallacies are a manifestation of a criminal personality; and 3) sex offenders can reduce their chances of offending by learning how to manage problems, recognize criminal thinking and understand their pattern of offending.

A decision-making model should be introduced as the core structure in which all participants' problems will be addressed. This can occur most effectively if a step-by-step procedure is applied, one which encompasses the elements of sound decision making.

The offenders' failure to make good decisions should be processed in terms of the thinking errors which are part of the criminal personality make-up, as identified by Yochelsen and Samenow (1976). The model should include ways to counter these errors. For instance, failure to plan ahead and failure to consider others' feelings could be countered with a step

to assume the worst about the possible consequences of a particular decision and a step to empathically consider impact to others or others' reactions. Participants must be taught to consistently employ the counter-thinking at specific points in decision-making. Two months is the recommended time period in which the decision-making model can be taught and practiced so that offenders become habituated to using it in the sessions. During this period, application of assertion, empathy and social skills should be gradually integrated into the problem-solving procedure.

Sex Abuse Cycles

The second two months are to be devoted to educating the participants on sex abuse cycles. A comprehensive model should be the basis, one which includes relevant life history events and developmental changes, antecedent thoughts, feelings, behaviors and situations, deviant fantasies, pre-offense planning, the offense itself, and post-offense experiences.

All participants are to be required to provide an account of their offense for which they have been convicted as well as other known offenses and a chart or report of their cycle in accordance with the model.

The group leader must confront any inconsistencies between the offenders' versions and official accounts. Various forms of denial should be examined and attacked by the groups, including minimization, rationalizations, and cognitive distortions. Ultimately the official versions and other documented information about the offenders' histories should prevail as the source from which the cycles are developed.

Problems emerging during this phase should continue to be addressed using the decision-making model.

Relapse Prevention

Once the group members have demonstrated competent levels of understanding of the

first two areas, the Pithers model of Relapse Prevention is to be introduced. The remainder of the training is to be devoted to assisting the participants in devising interventions into their cycles. Problems arising during this phase should be examined in terms of how the offender may have lapsed and the consequences that would ensue if he does not apply the appropriate interventions.

It is essential that the group leader stress that relapse prevention is an ongoing process. On a daily basis they must formulate new strategies, cope with new situational triggers and stressors, and grow increasingly creative and resourceful in managing their lives and reducing their own risk of offending.

Differential Presentation of Models

The Pithers model is readily suited to the Type B offender. These individuals generally are able to understand and integrate the model's concepts and terminology. Their offense cycles often have situational stressors or other triggering stimuli which by virtue of their repetitiveness in the cycle, are relatively apparent. A Type B offender will also have a limited history of antisocial activities not related to sexual offending and thus he can focus on addressing a cycle which culminates in deviant sexuality.

The following modifications need to be made in presentation of the models to Type A and Type C offenders, respectively.

Relapse Prevention Training with Type A Offenders

The Type A participants typically perform poorly in treatment. This is often due to their lack of self-discipline and their failure to comprehend therapy concepts. This training can assist the offender in learning step-by-step ways to manage his problems and, by presenting the concepts of change to him in a clear and simple fashion perhaps motivate him to perform better in therapy.

Audio and visual aids and roleplaying are key tools in effectively educating these individuals. The language of the Pithers model must be modified to meet the level of Type A's. The acronyms (PIGS, SUDS) can be grasped and because of their usefulness as a mnemonic device should be frequently employed. Simplified terms should be provided for all components of the model and once adopted, must be used consistently (for instance, abstinence violation effect and lapses might be termed "downward sliding"). Metaphors can often enhance communication with this group (for example, viewing the overall model as a map with varying routes which are upward, downward and lateral).

Clearly there is room for creativity on the part of the leader. It may be desirable to explain the outline of how relapse occurs and have the participants offer their own terms. This not only insures the terms are understood but also stimulates the group members into conceptualizing patterns of their cycle. The latter is especially important with this group as they tend to be overly compliant and may readily concur with ideas presented by the group leader and even apply assigned terminology without any actual internalization of meaning. A consistent language and framework should be adopted and strictly adhered to. The terminology must be workable and synonymous with that in the Pithers model, yet at a level meaningful to the participant.

It is critical that the leader maintain the stance that lack of education and/or mental impairment do not suffice as excuses for irresponsibility. These individuals have typically used their limitations to play on others' sympathies in attempts to escape the consequences of their actions. They need to be confronted when they display this behavior and required to focus on those aspects of their life of which they are able to control and change, regardless of real or perceived limitations.

Relapse Prevention Training with Type C Offenders

Type C offenders represent the greatest threat to society of those described in this paper. At the core of their sexual offending is a deeply entrenched set of cognitive distortions. These distortions color virtually all aspects of the offender's life and manifest themselves in a wide variety of antisocial activities.

The Type C participant should be required to identify all the major outcomes of his criminal thinking, including sexual assault. He must develop a cycle as to how each of these occurs. These may be intertwined with the sex assault cycle or may even run parallel to it. Of primary emphasis should be those fallacies which comprise criminality, as identified by Yochelsen and Samenow (1976).

The Type C offender's sexual assaultiveness may have its roots in misogynistic thinking, or may be a part of his power thrust behavior. It may also be a reflection of his opportunistic nature and his view of people as objects designed to meet his wants.

While there may be key triggers and high-risk situations that predispose his offending, these generally need not be present in order for him to offend. Rather, the whole fabric of his thinking sets the stage for his offending. Type C offense cycles should have as their main focus the criminal thinking errors with specific correctives to this thinking. The Yochelsen and Samenow work offers such correctives. It is the group leader's role to educate the offender about criminal thinking and aid him in identifying his errors. The offender must recognize how these negatively effect problem-solving and how these occur in patterns. While he should be aware of events and environment cues which could reinforce his criminality, it should be stressed that controlling these is a relatively minor element in his Relapse Prevention plan.

Assignment of Probation and Parole Sex Offender Specialists

In order for this project to be carried out successfully, the implementing district must

assign officers to specialize in the supervision of sex offenders. The number of officers thus designated in each district should logically be determined by the number of sex offenders being supervised there. There should be a sufficient number to cover the general pre-sentence investigation and supervision duties and to conduct the two-hour training sessions weekly of each Type A, B and C groups.

In order to deal with the dilemma of overly large groups and a shortage of trained, competent officers, we suggest a priority system for offender inclusion be adopted. Since each offender must complete the program prior to discharge from supervision, a workable plan may be to first accommodate those offenders approaching the end of the supervision period but having a minimum of six months left. Or, in those communities where resources are few and the offenders is receiving no other types of intervention, it may be prudent to prioritize those just sentenced to serve a period of probation or released on parole.

It is imperative that the officer assigned to specialize in sex offender supervision be carefully selected. Failure to do so could result in an adverse outcome for the entire project.

With regard to personal traits, a model established for sex offender therapist selection identified certain features deemed necessary in order to insure provision of effective services and to minimize risk to the community (O'Connell, Leberg and Donaldson, 1990). These features include the abilities to maintain objectivity, to remain realistic about sex offenders, to spot and address manipulation, and to confront appropriately. Admittedly, the officer's role will be different than that of the therapist. However, it can be reasonably assumed that these traits are desirable in any professional interacting with the offender in the criminal justice or mental health system.

It is also important to select officers who recognize the distinction between conducting therapy and facilitating change via education. Officers who have failed to respect these

boundaries and have inappropriately blurred their role of officer with that of a counselor would not be suitable for this project.

We have observed that many competent, experienced officers feel intimidated and inadequate when faced with the task of sex offender supervision. If officers are trained to recognize sex offending as a manifestation of criminal thinking and to focus on this aspect of the offender, they will be better prepared and feel more self-assured in accepting this task.

In addition, we recommend that the officers assigned to this project have a minimum of three years field experience supervising offenders and have been trained in the areas of sex offender pathology and the Pithers model of Relapse Prevention, with emphasis on how to identify and monitor relapse indicators.

Each probation and parole district has a responsibility to identify those sex offender treatment specialists in their region. Those officers designated for this project should receive formal training in the above areas, either through individual contact or via professional seminars.

As stated earlier, ideally the training sessions should serve as an adjunct to therapy the offender is undergoing. When this is occurring, the therapist and parole officers must maintain regular contact and the offender must be advised of the terms of limited confidentiality regarding confidences he discloses that lead the officer or therapist believe he is reoffending. A minimum of one contact weekly should be made, during which time each the officer and the therapist provide a summary of the client's progress or lack of it. Therapists should be asked to attend and permitted to co-lead the training sessions.

In communities where treatment resources are scarce or unavailable, the officer should nevertheless maintain the stance with the offender that he should continue to seek formal treatment services which are compatible with this project's philosophy.

While there are apparent limitations in the project described herein, it need not be merely an attempt to fill the gaps in sex offender management and treatment. If enthusiastically undertaken and pursued, this project can serve as a springboard from which probation and parole agencies can stimulate the interest of community mental health agencies and generate a network to address this problem thoroughly and consistently.

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SEXUAL ADDICTION AND MID-LIFE CRISIS

&

COPING RESPONSE STYLE OF PARENTS WITH ONE
CARETAKING PARENT WHO ABUSED ALCOHOL

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Sexual Addiction and Mid-life Crisis

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Mid-life crisis has been likened to a time when individuals become aware of their mortality and question the existential meaning of life. For those who have struggled to mask their feelings, this time of life can be frightening. Thoughts which have been submerged in order to succeed, excel or function in a certain manner, often break through the self-imposed barriers and seek expression in everyday living. Some poets describe this as madness; many novelists utilize this reawakening of all emotion including desire to propose unique and unusual circumstances for the usually straight-laced, individual who obeys all rules.

It is common during midlife to recognize the waning of youth and struggle to recapture times gone by. Loss is an operative issue, which often impels its victim to attempt to recapture feelings, forms of attention or objects which were impossible to attain due to the life decisions made in youth. Often these decisions revolved around home, family and career. At midlife, a blurring of goals and personal boundaries appear to allow the individual to reevaluate past, present and future goals and seek not only a new direction but recovery of that which is lost--metaphorically through objects gained and experiences relived to recreate/recapture youth.

During this time, reckless sexual encounters can lead to sexuality being misconstrued as love. Sexual addiction can occur in which sex is equated with "real" love, youth, and renewal. The boundaries of secret lives and false identities are blurred with reality. Eventually, a never-ending cycle can occur: seeking pleasure and lust in the hope of obtaining love.

Sexual addiction is similar to all addictions. Risk factors include

(a) being reared in a dysfunctional family (b) lowered self esteem (c) a history of emotional, physical and sexual abuses (d) being close to sexually addicted significant others and to the influences of other addictions and compulsions, particularly drugs. (Carnes, 1983)

The Addiction Cycle

"Sexaholics" recycle endlessly through a circle of addictive experiences, according to Carnes (1983).

1. Preoccupation: At this preliminary stage, a sex addict's mind is preoccupied with sexual thoughts and fantasies. A person becomes so obsessed with sex that every relationship and acquaintance is viewed as an opportunity for sexual gratification.

2. Ritualization: As with other types of addicts, the sex addict creates their own unique rituals which intensify the obsessions, excitements and arousals. Watching from a special vantage point, repeatedly walking the same route or using special surveillance equipment to eavesdrop are examples of possible rituals.

3. Compulsive sexual behavior: Sexual addicts appear powerless to control their sexual appetites. Risky or dangerous behavior is elected in order to satisfy their sexual need. Engaging in the sexual act itself is the prime purpose of preoccupations and rituals and, ultimately, could occur at the cost of losing one's reputation, job, relationships and, in some instances, life.

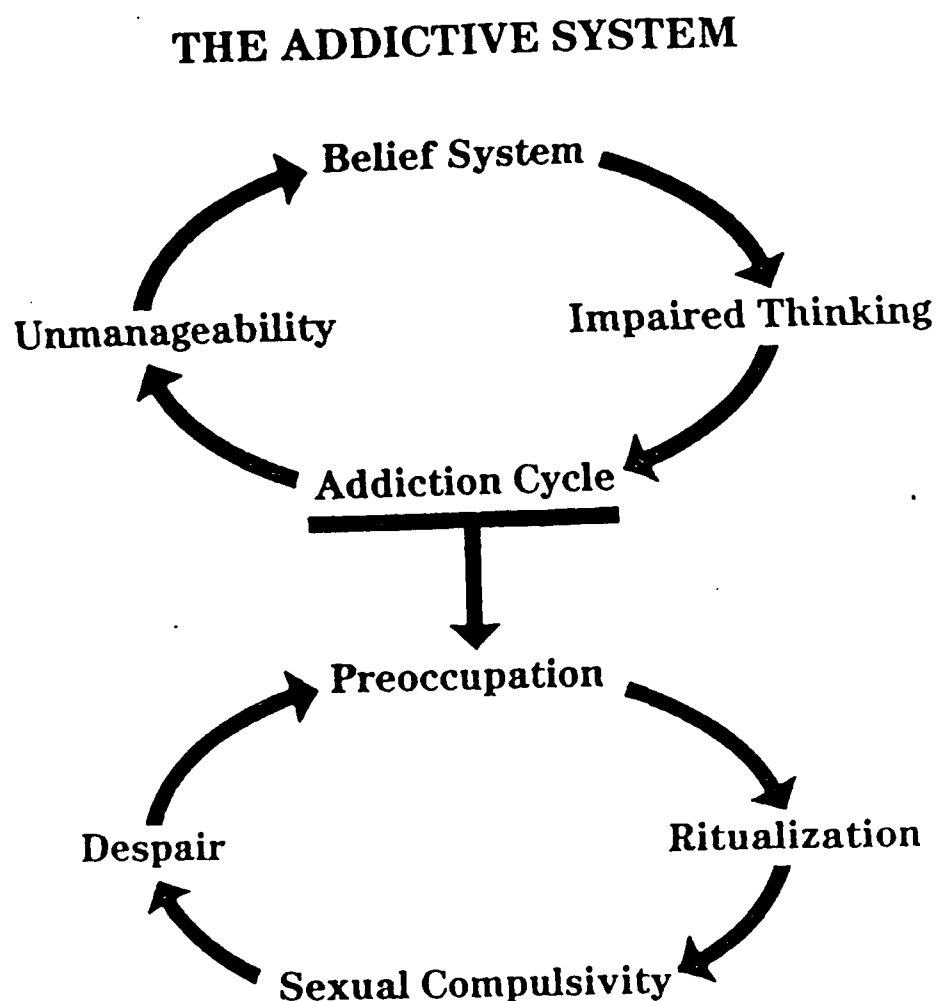
4. Despair: The final outcome of engaging in sexual compulsion and risky behavior is for sexual addicts to become aware of the self-degradation they have created and the resulting feelings of self-hatred and self-pity. Upon reflection, sexual addicts condemn their indulgences and acts. They are filled with self-loathing and self-blame which often leads to despair, depression and, ironically, to alleviate these symptoms, sexual addicts repeat step one and engage in the entire cycle once again.

Treatment Methods and Modes

Treatment can be varied. In many cities, there are twelve-step groups similar to Alcoholics Anonymous which emphasize the individuals powerlessness and need to gain strength from a higher power and the support of others. Conversely, Kirby (1992) postulates that the individual must come to understand and value the impulsive part of the self which creates addiction, thereby robbing it of power and control. She suggests that this

is best accomplished in individual therapy with an adjunct experience of an educational/discussion/support group.

Figure 1



Kirby (1992) has developed a brief model of treatment which includes recognizing the addicts beliefs and belief system; their impaired thinking

distorted reality and negative self bias; their preoccupation with sex and exclusion of other pleasurable thoughts and activities from normal daily routine; and their ritualistic risky and self destructive behavior. As with Carnes (1989), Kirby advocates cognitive behavioral intervention coupled with supportive individual and group therapy. She also stresses the need for medical and psychiatric consultation when appropriate. Kirby and Francisco (1992) note that medication can be particularly helpful in managing unusually embedded obsessions, anxieties and deep depression.

It is important to note that sexual addiction occurs in both genders and all sexual orientations. Sexual addiction can be masked by other addictions and can occur in individuals of all walks of life, races, religions and occupations. Since sexuality and youth are inextricably tied together by media, myth and metaphor in our society, it appears that individuals are particularly at risk of sexual addiction during periods of self reappraisal such as often occur during mid-life.

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Coping Response Style of Parents With One
Caretaking Parent Who Abused Alcohol

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How individuals resolve stress appears to be an important cue to their general functioning and a particular cue regarding the likelihood of future problem solving abilities. Moos (1990) has developed an inventory which measures both positive and negative coping responses and yields a profile of standard scores (mean=50, s.d.=10.) These scores have been standardized on a normal population and utilized with special populations including addictions, mental health problems, medical problems and community functioning and problem solving. (See Table 1)

Moos, Finney & Chan (1981) found that reliance on avoidance coping is associated with alcohol abuse. In addition, Cooper, Russell and George (1988) surveyed problem and nonproblem drinkers and found that individuals who suppressed their anger and relied on avoidance coping responses were more likely to consume alcohol in order to cope with stressors. It appeared that, in turn, these individuals drank more and were more likely to experience problems due to excessive alcohol intake.

Moos and Brennan (1990) have found that even after controlling for demographic factors, stressor characteristics, challenge appraisal and social resources, coping responses were predictably related to the functioning criteria of individuals who reported at least two recent problem drinking episodes. They found that, for these individuals, more reliance on cognitive avoidance and emotional discharge was associated with more

depression and physical symptoms than with controls. Also, positive reappraisal was associated with more self-confidence and less depression. Emotional discharge was related to more drinking problems. Googins and Casey (1989) found that wives of men who abused alcohol reported higher levels of avoidance coping.

Table 1

Moos Coping Responses Inventory
Subscales and Descriptions

Approach Coping Responses	
1. Logical Analysis	Cognitive attempts to understand and mentally prepare for a stressor and its consequences
2. Positive Reappraisal	Cognitive attempts to construe and restructure a problem in a positive way while still accepting the reality of the situation
3. Guidance/Support	Behavioral attempts to seek information, guidance or support
4. Problem Solving	Behavioral attempts to take action to deal directly with the problem
Avoidance Coping Responses	
5. Cognitive Avoidance	Cognitive attempts to avoid thinking realistically about a problem
6. Resigned Acceptance	Cognitive attempts to react to the problem by accepting it
7. Alternative Rewards	Behavioral attempts to get involved in substitute activities and create new sources of satisfaction
8. Emotional Discharge	Behavioral attempts to reduce tension by expressing negative feelings

How, then, do individuals whose role models during their youth emphasized reliance upon negative coping function as adults? Do these individuals mimic their parents and show heavy reliance upon negative coping, thereby, transmitting a vulnerability toward alcohol misuse intergenerationally?

Tolton (1988) found that adult daughters of alcoholic and nonalcoholic parents did not differ on all indices of approach and avoidance coping on the Moos Coping Responses Inventory.

In a survey of adults who had been licensed as foster parents, Kirby (1992) found that survey respondents who reported alcohol abuse by one of their caretaking parents did not report reliance on avoidance coping. In fact, foster parents who reported alcohol abuse by one caretaking parent did not differ significantly from the population at large. They reported feeling anger slightly more often in response to loss issues and, also, reported the frequency of other emotions in response to loss identically to the other survey respondents.

Differences were found, however, in individuals who reported that they relied on negative coping responses as methods of handling the stressor reported on the inventory. These individuals appeared to take a negative stance, in general. They reported that the behavior of the last foster child to leave their home as much more difficult than foster parents who reported relying more heavily on positive coping responses. In

addition, these individuals rated their satisfaction with their role of a foster parent more negatively, their recollection of events in childhood more negatively and the report of happiness in childhood less frequent. Survey respondents who relied more heavily upon negative coping responses were composed of a proportional representation of the population at large, for the factors of childhood experience including childhood physical abuse, emotional abuse, neglect, sexual abuse, and, also, drug and alcohol abuse and domestic violence within the family of origin.

Foster parents who reported alcohol abuse by one parental caretaker comprised 32% of the survey respondents. Since the total response was 218 individuals, this study should be considered preliminary. A larger sample is required to substantiate these findings, however, it appears that successful parents, by foster parent licensing standards, who are capable of caring for children with a myriad of problems and also were exposed to alcohol abuse in their parental home, learned, in some manner, to rely on approach coping more frequently than avoidance coping.

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**RESIDENTIAL EVALUATION PROGRAM FOR
MENTALLY ILL AND MENTALLY RETARDED PROBATIONERS
IN BEXAR COUNTY, TEXAS**

BY

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ROBERT McKEE, BA

JEFFERY A. WILLIAMS, BA

**RESIDENTIAL EVALUATION PROGRAM FOR
MENTALLY ILL AND MENTALLY RETARDED PROBATIONERS
IN BEXAR COUNTY, TEXAS**

INTRODUCTION:

Currently no residential facilities, other than this contracted facility, excluding the San Antonio State Hospital and private hospitals, exist in Bexar County; that provides a residential setting conducive to evaluating the total array of psychosocial needs of the indigent offender (whether adjudicated or pending charges, as well as probated or not). Also, having been diagnosed with a chronic or acute mental health disorder and/or mental retardation problems.

The Bexar County Jail has become a million dollar a year holding cell for many mentally ill people who should be in psychiatric facilities rather than behind bars.

At any given time, more than 100 offenders with diagnosed psychiatric disorders are incarcerated in the Adult Detention Center often for months at a time. Whether pending Motions to Revoke Probation action, or other charges, each mentally disabled person housed in the Adult Detention Center costs taxpayers more than \$50.00 dollars per day, and occupies valuable bed space that otherwise would be available for felons.

Figures obtained from the Medical/Psychiatric Department of the Bexar County Detention Center indicates that 15% of the offender population currently on probation are identified as having mental disabilities. There are approximately 27,000 individuals on probation, with about 4,050 already identified as having similar problems. The Bexar County Adult Probation Department is not equipped with available resources for mentally disabled individuals.

GOAL:

The goal of this project is to reduce the population of mentally ill and mentally retarded Bexar County residents at the Bexar County Adult Detention Center and/or to act as an alternative to incarceration of mentally ill probationers residing in the community.

PROGRAM DESCRIPTION:

The Center for Health Care Services (The Center) designed a residential based evaluation program for assessing the needs of mentally impaired individuals and linking them to resources so they can obtain their optimum level of functioning in the community and comply with their conditions of probation.

The program consists of a 14 bed non-secured residential facility which is staffed on a 24-hour basis. The probationer resides in the home for approximately 90 days while all phases of the evaluation are completed.

Probation Officers and Mental Health staff of the Bexar County Detention Center identify mentally ill and mentally retarded offenders to be referred to The Center for Health Care Services.

The offender will be referred to the Center's Residential Services via the Forensic Case Management Unit. The case manager will screen and coordinate the admission process if appropriate and act as the liaison between the Probation Department , the Bexar County Detention Center and The Center for Health Care Services throughout the contracted evaluation period.

An interdisciplinary evaluation inclusive of a psychiatric, medical, social, educational and psychological evaluation is completed and recommendations for management in the community is provided to the probation officer upon discharge from the residential setting.

PROGRAM DESCRIPTION (CONTINUED):

The offender will be continued in Center services as needed to include psychiatric treatment, psychosocial services, day activity, 24-hour forensic case management, etc. on an outpatient basis to determine the effectiveness of the implementation of their recommendations during the initial implementation phase. An evaluation will be conducted after 30 days and feedback will be provided to the probation officer. A determination will be made by the probation officer to continue or terminate the contracted services.

OBJECTIVES:

1. Identify mentally ill and mentally retarded offenders who are Bexar County residents residing in the Bexar County Adult Detention Center.
2. Identify mentally ill and mentally retarded Bexar County residents who are presently on probation and are at risk of their probation being revoked due to behavior(s) related to a mental or emotional disorder.
3. Develop a comprehensive management plan inclusive of all community services and support systems needed by offenders who receive the contracted evaluation and are recommended for probation or continued probation utilizing such a plan.
4. Evaluate offenders' potential for management or continued management in the community, as a probationer, if a comprehensive management plan is developed and implemented during the probation period.
5. Implement and evaluate the effectiveness or service provisions designated in the management plan.

TARGET POPULATION:

Individuals considered for the evaluation are selected from the following categories:

TARGET POPULATION (CONTINUED):

Pre-trial Investigation: This includes mentally ill and or mentally retarded offenders who; a) are awaiting trial with misdemeanor or other charges; b) can qualify for a Personal Recognizance Bond; and c) have been assessed by the county psychiatrist as not presenting a high risk or danger to the community or Center staff, if released to reside in the residential facility. If the evaluation results in a favorable recommendation for managing the individual in the community, the county psychiatrist will utilize the information to testify in court on behalf of releasing the individual on probation. This should result in speeding up the adjudication process for this population of Bexar County residents.

Pre-Sentencing Investigation: After a trial has occurred and the above process has not been completed, the probation officer conducting the pre-sentencing investigation will identify offenders who they have assessed to be mentally ill and refer the offender to The Center for screening for possible admission to the program.

Motion to Revoke Probation: When the offender is non-compliant with the conditions of probation and the probation officer believes it is due to a mental impairment, the individual will be referred to the program as an alternative to incarceration.

A FORENSIC CASE MANAGER WILL BE ASSIGNED TO:

1. Conduct an initial assessment to determine appropriateness for the contracted evaluation process.
2. Determine if the offender requires crisis/emergency stabilization services before commencing the evaluation process and link the offender to the appropriate service.
3. Provide liaison services between the Probation Department, the Bexar County Detention Center, the Courts and Center clinical evaluation team during the admission of the offender in The Center residential facility and coordinate the total process for each offender, until the individuals contract period is terminated (approximately 90 days) which can be extended at the request of the probation officer.
4. Case Manager will assist the probation officer in presenting the management plan to the courts and arrange for continued contracted evaluation services (contracted services provided after the residential phase is completed). Also, the Case Manager will assist during the management plan implementation phase, when requested by the probation officer, based on a need to evaluate the effectiveness of the management plan implementation.
5. The case manager will assist probation officers with service brokering within The Center and community as designated in the management plan.

STATISTICS:

- a. Forty-nine (49) offenders were served.
- b. Of the 49, 24 were given the option of their probation status being revoked if the program was not utilized.
- c. Of the above 24, 15 were not reincarcerated/sent to prison.
- d. Three (3) PSI status offenders were placed in the program and 1 was not additionally incarcerated.
- e. Twenty-two (22) were not at risk of revocation but were considered management problems which may have led to revocation of their probation status. Of this 22, 14 were not additionally incarcerated.
- f. These statistics cover a 10 month period beginning 11/90 through 8/91.
The success rate is 61.22% with success defined as no further incarceration.
- g. The program is funded by the Bexar County Adult Probation Department (FY 91 was funded for \$495,000).

RELAPSE PREVENTION

WORKSHOP MATERIALS

G. Alan Marlatt

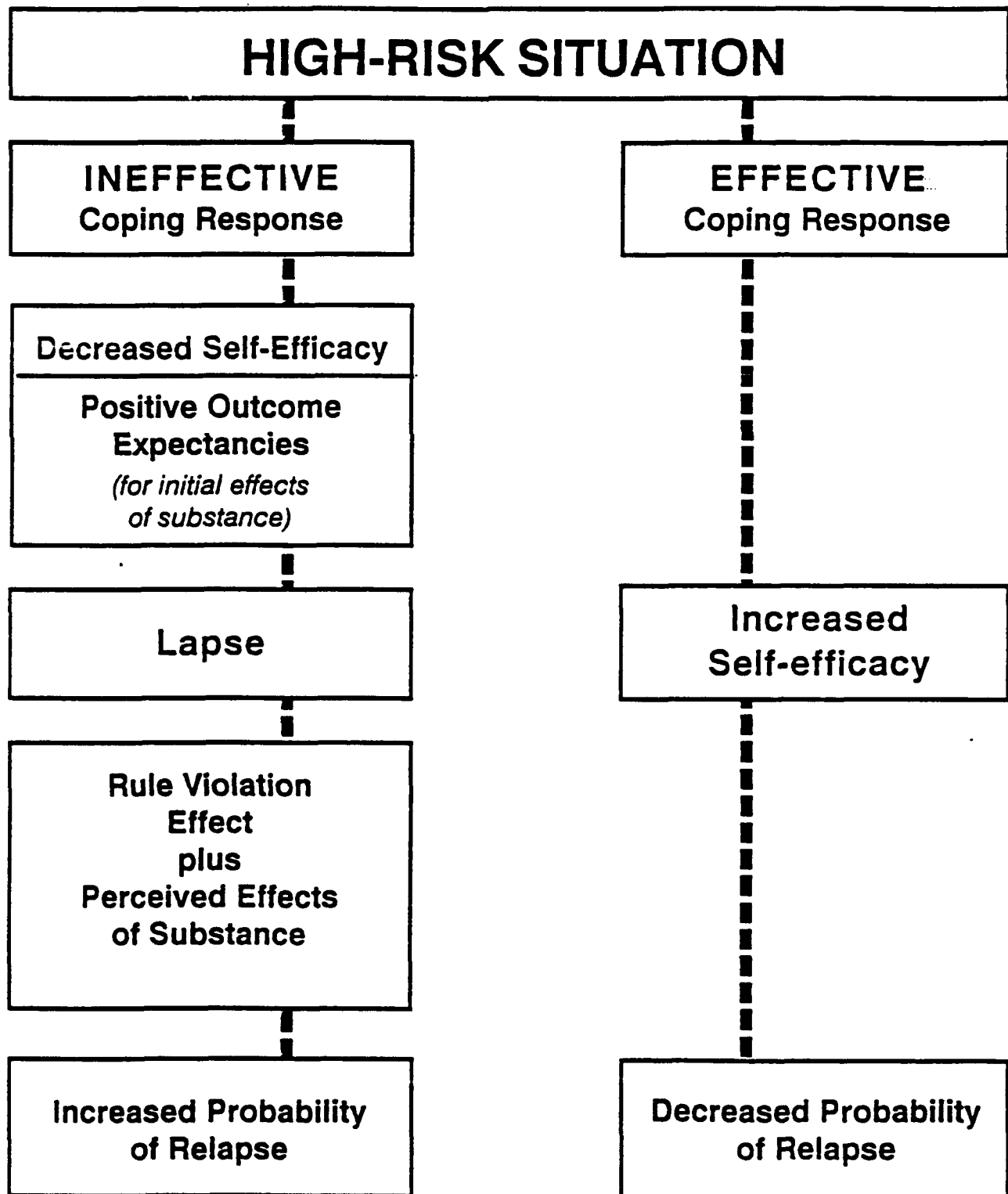
**DEPARTMENT OF PSYCHOLOGY
Addictive Behaviors Research Center
University of Washington
Seattle, WA 98195**

ANALYSIS OF RELAPSE SITUATIONS

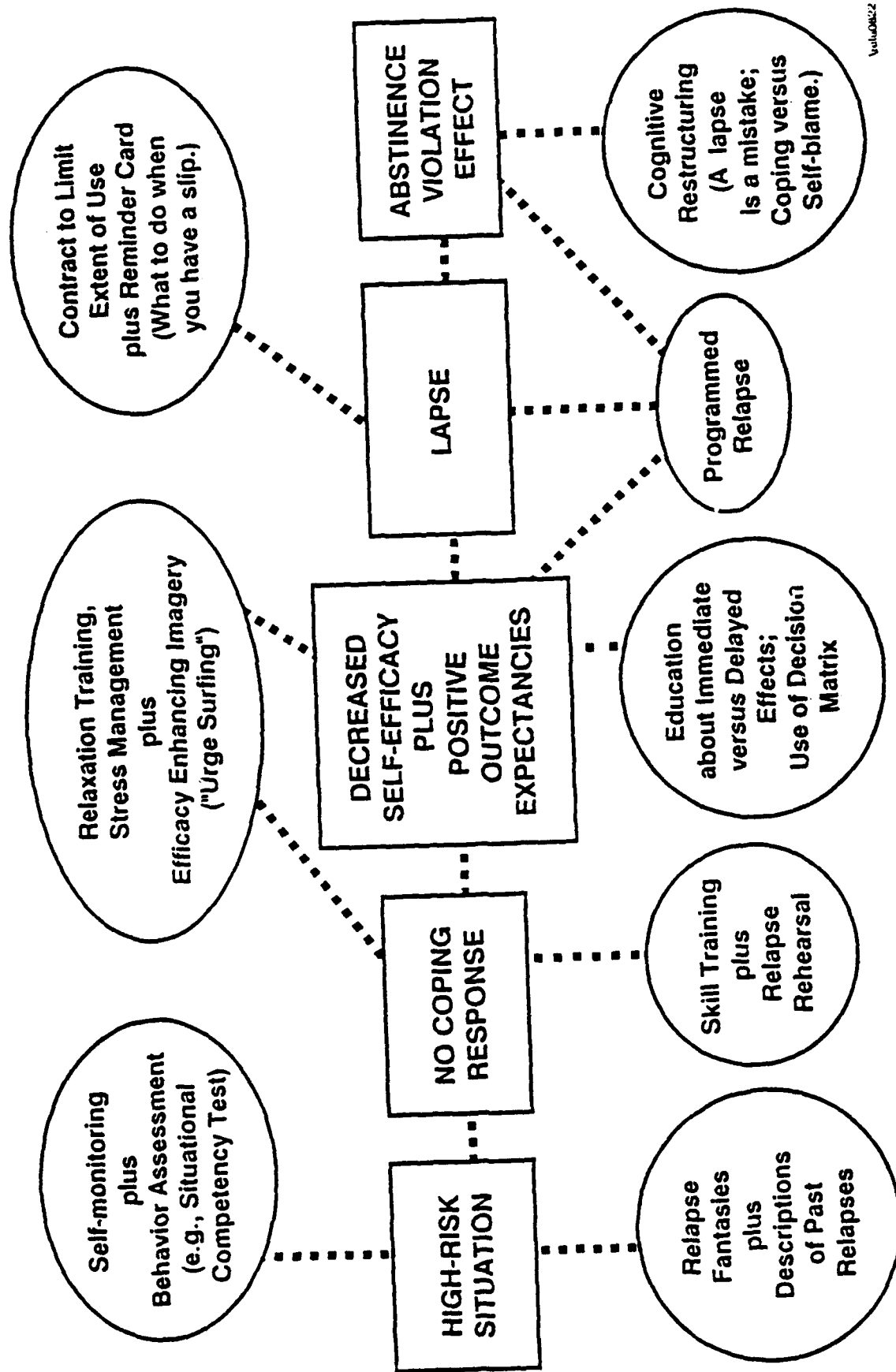
with Alcoholics, Smokers, Heroin Addicts, Compulsive Gamblers and Dieters

RELAPSE SITUATION	Alcoholics (N = 70)	Smokers (N = 64)	Heroin Addicts (N = 129)	Gamblers (N = 29)	Overeaters (N = 29)	TOTAL (N = 311)
INTRAPERSONAL DETERMINANTS						
Negative Emotional States	38%	37%	19%	47%	33%	35%
Negative Physical States	3%	2%	9%			3%
Positive Emotional States		6%	10%		5%	4%
Testing Personal Control	9%		2%	16%		5%
Urges and Temptations	11%	5%	5%	16%	10%	9%
TOTAL	61%	50%	45%	79%	48%	56%
INTERPERSONAL DETERMINANTS						
Interpersonal Conflict	18%	15%	14%	16%	14%	16%
Social Pressure	18%	32%	36%	5%	10%	20%
Positive Emotional States	3%	3%	5%		28%	8%
TOTAL	39%	50%	55%	21%	52%	44%

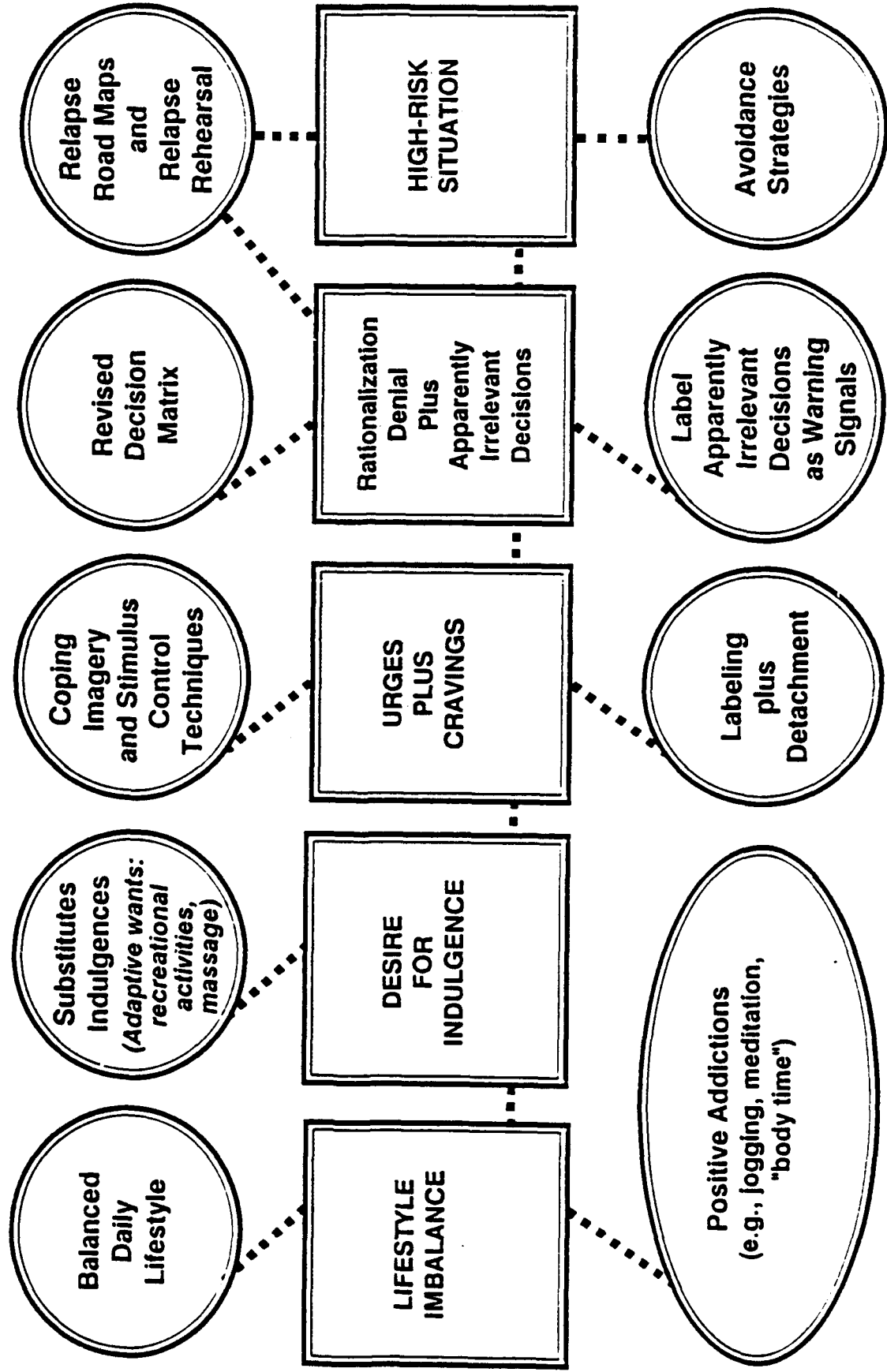
Cognitive-Behavioral Model of the Relapse Process



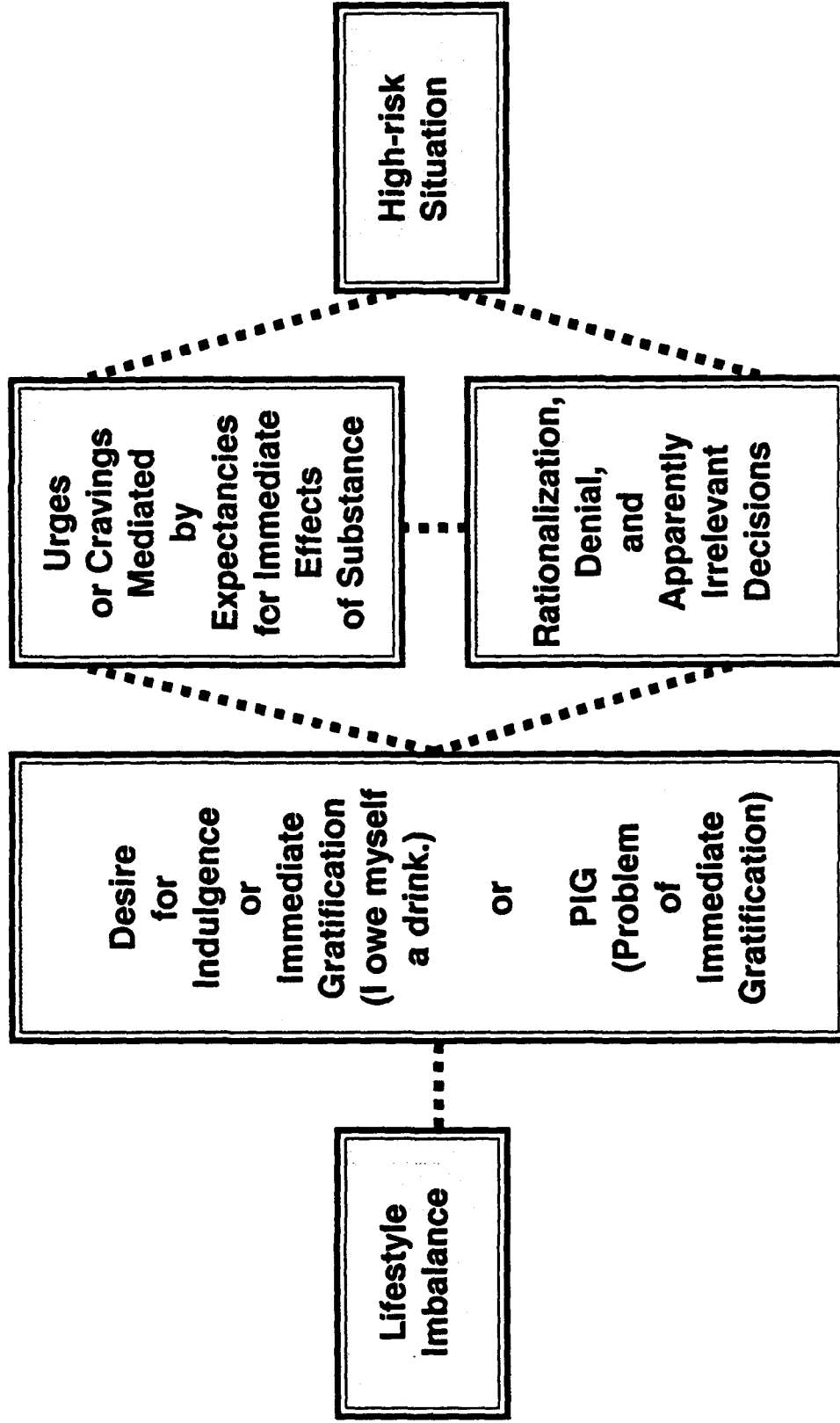
Relapse Prevention: Specific Intervention Strategies



Relapse Prevention: Global Self-control Strategies



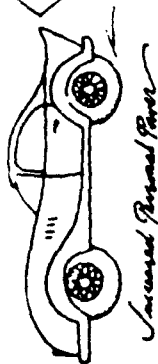
Covert Antecedents of a Relapse Situation



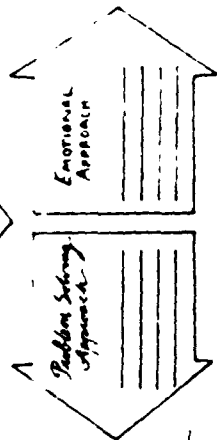
An Attribution Model of Addiction and Relapse

Responsible for Changing Problem? (Is person capable of changing without self-help or treatment group?)			
YES		NO	
Personally Responsible for Development of Addictive Behavior? YES	Moral Model <i>(Relapse = Sin)</i>	Spiritual (12-step) Model <i>(Relapse = Loss of contact with Higher Power)</i>	
	Biopsychosocial Habit Model <i>(Relapse = Mistake/Error)</i>	Disease Model <i>(Relapse = Reactivation of Progressive Disease)</i>	
NO			

The Self Control Road Map

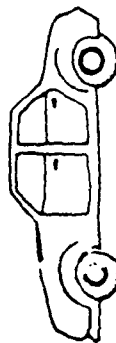
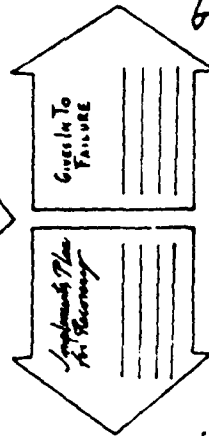
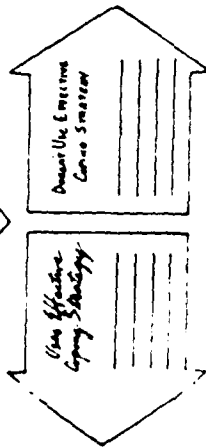
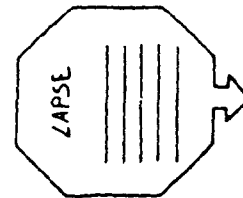
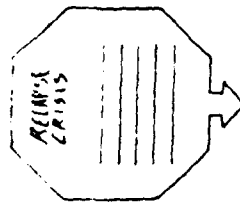


Secured Personal Power

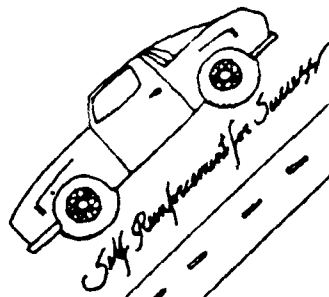


"Chart Your Route Before You Start Out"

COMPLETE EACH BOX AS EFFECTIVELY AS POSSIBLE. EFFECTIVE PLANNING NOW WILL SAVE YOU VALUABLE TIME AND PREVENT NEEDLESS DETOURS AND BREAKDOWNS LATER.



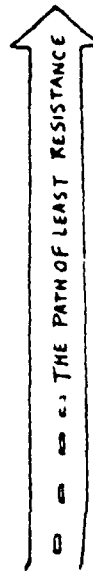
Develop New Coping Strategies



Self Reinforcement for Success

"Watch For Warning Signs"

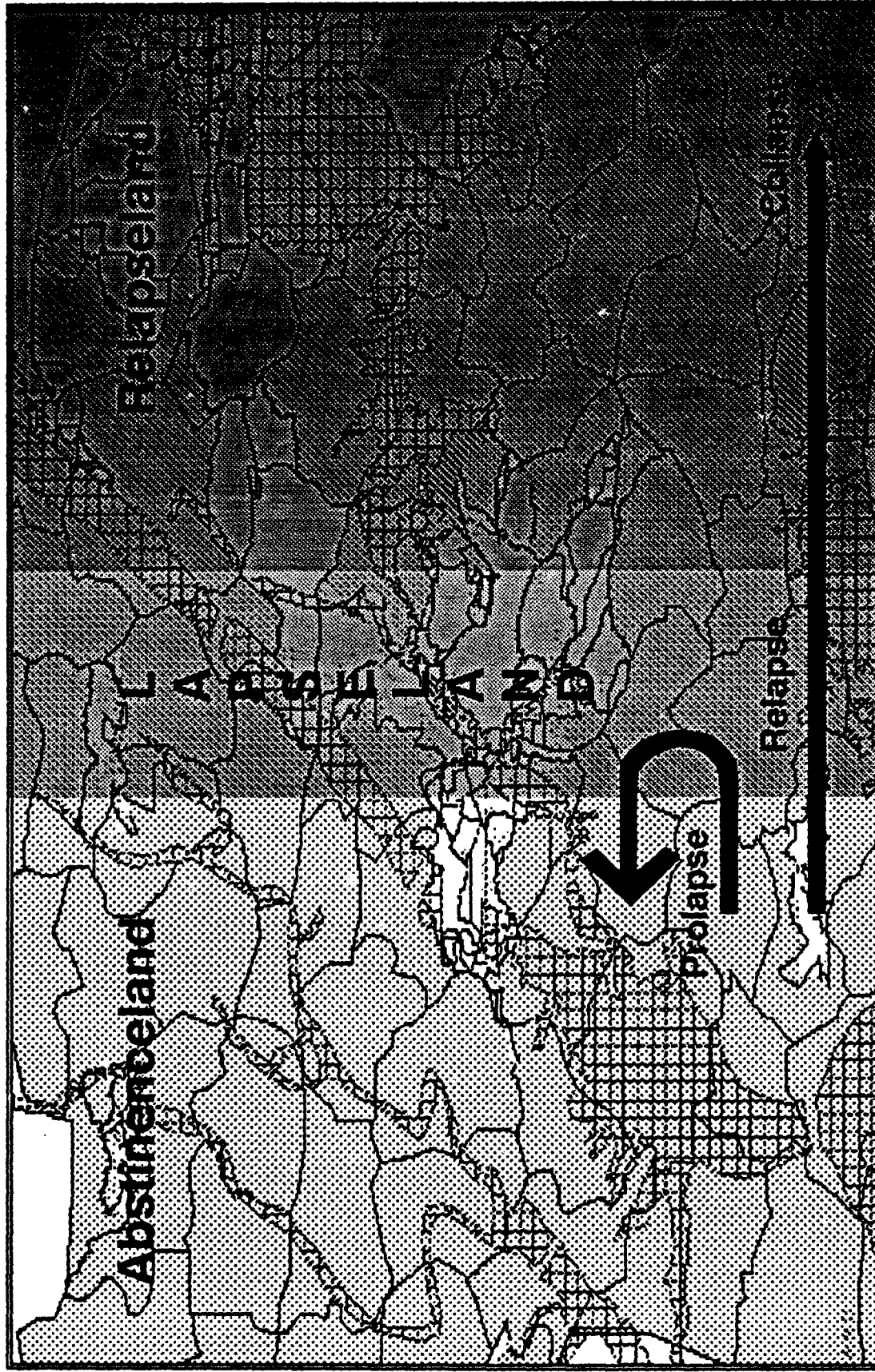
WATCH OUT FOR HAZARDOUS CONDITIONS AND TAKE IMMEDIATE ACTION.



REPAIR



Map of Lapse, Relapse, Prolapse and Collapse Lands



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RET, THE CRIMINAL PERSONALITY, AND RELAPSE PREVENTION:
IN-CUSTODY TREATMENT TO REDUCE RECIDIVISM

BY

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FEDERAL PRISON SYSTEM
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**RET, The Criminal Personality, and Relapse Prevention:
In-Custody Treatment to Reduce Recidivism**

by William K. Marek, Ph.D.

Few social problems are more important or more enduring than that of violent crime. The program the author uses as a psychologist in a Federal prison hinges on Rational Emotive Therapy (Ellis, 1962) and its relation to the origin and nature of beliefs, emotions, and consequences. Since behaviors are powered by beliefs, RET and Relapse Prevention are employed in the context of the Criminal Personality to change belief systems to promote personally beneficial, prosocial behaviors. The program is didactical, confrontational (where necessary), based on strict Personal Responsibility, and allows for no obfuscation, excuses, mitigating circumstances, justifications, denials, or rationalizations.

The inmates are first taught the basics of RET since it is the cornerstone on which all other elements of the program stand. RET emphasizes the primacy of choice, beliefs, and Personal Responsibility over outside circumstances. In fact, with the exception of human touch, psychosis, severe trauma, or drugs, it is the person's belief system that dictates the consequence or emotion. Criminals tend to blame outside circumstances for their actions, believing they had "no choice" but to commit the crime. Other irrational, criminogenic beliefs include "I 'deserve' this, he 'shouldn't' have done it, he 'can't' do that to me, I'm a 'victim', I'm 'unable' to stop committing crimes, society is 'designed' to make you fail, 'everyone' does it, and my 'needs' are more important than yours." These self-serving beliefs are vigorously disputed with facts and analogies. Some facts that tend to underscore the importance of choice and Personal Responsibility in choosing crime include the following:

****1990 census figures show that 33.6 million Americans (13.5% of our total population) lived on \$13,359 (the official poverty line) for a family of four. The official poverty line for an individual in 1990 was \$6,652.**

****As of January 1, 1991, the state and federal prison population reached 771,243. The total number of Americans who are on some sort of probation, parole, house arrest, or halfway house is approximately 775,000, so the grand total of Americans under some sort of official penal scrutiny comes to roughly 1.5 million. There are approximately 260 million Americans.**

****Manual Arts High School in Los Angeles (the school is located in "South Central," one of the most notorious, economically depressed, and violent areas for gang activity) has 2,500 students. The principal of the school believes 200 Manual Arts students are involved in gang activities.**

****One in seven Americans is illiterate.**

****The IQ of the average BOP inmate is 100; only one-half of them have finished high school.**

****One in four black American males between the ages of 18 and 30 is under some sort of penal scrutiny.**

****10% of the drinkers drink 50% of the alcohol.**

The author mentioned that facts and analogies are central to his program. Although the author cannot empirically PROVE that crime is a result of choice, neither can misguided sociologists and apologists lay the responsibility for crime on, for example, a "lack of recreational facilities" in a neighborhood. If poverty causes crime, why are not 34 million Americans in prison? If a bad neighborhood leads inevitably to crime and gang activity, why are not more Manual Arts students in gangs? If illiteracy tends to foster crime, why is not one in seven Americans in prison? If inmates have an average IQ, why do so few of them graduate from high school? The author knows of no data proving why so few graduate; personal experience indicates inmates believe school is BORING, they are "too cool for school," don't believe they need "book learning," and lack the desire (not the ability) to live and behave responsibly. By questioning criminals at length, the author has formulated a belief that most criminals come from average families and neighborhoods. If 25% of black males between 18 and 30 are in trouble with the law, that means 75% of them are not and is probably more a reflection of how local law enforcement agencies choose to focus their attention (on the little, easy-to-catch individual).

Personal experience has taught the author that most criminals use drugs because it is exciting and illegal. Many criminals LOVE amphetamines because it makes them feel powerful and important. As youths, they committed crimes long before they ever took an illegal substance.

Most drug abusers are not in prison. Most alcoholics are not in prison. Although many statistical reports seem to indicate a relationship between drug usage and crime, it is the author's belief that drug usage makes it easier for the criminal to do what he wants to do anyhow (the crime). This is much in the same manner as individuals who go to a bar, have a few drinks, and find it easier to talk to persons of the opposite sex. If drugs caused addiction, many more people who received pain-killers after an operation would become addicted. Half of the men who were addicted to heroin in Vietnam used it again once they returned to the United States. Only one in eight (12%) became re-addicted here (Peele, 1991).

It is the author's belief that linking drug usage with hard-core criminality is indicative of the statistical maxim that "correlation does not necessarily mean causation." Although it is true that some criminals' sole *modus operandi* is to live to steal and use drugs, many criminals will spend a substantial portion of

their criminal proceeds on such non-drug behaviors as spending lavishly, tipping big, and playing the "big shot." If much of the money from a bank robbery is spent on items other than frenzied drug abuse, this militates against being able to lay the blame for the crime on the criminal's drug "problem."

Relapse prevention principles can be utilized with criminals and the concomitant problem of recidivism. Their criminogenic, antisocial beliefs seldom comport with helpful, prosocial beliefs and behaviors. Didactical, fact-oriented RET interventions are utilized to greatest effect when they modify inaccurate belief systems. The cognitive distortions held by criminals about the reality of themselves, their place in the world, and the world itself can easily lead even a well-intentioned criminal back into crime. The educative, self-management principles of RET and Relapse Prevention appear to offer much hope in reaching criminals who wish to learn how to stop committing crimes. For those many criminals who have no desire to discontinue their criminal activities, it can only be hoped that some portion of the Personal Responsibility tenets of RET and the "Own Maintenance Man" tenets of Relapse Prevention are acquired for future use.

Criminals evince much the same kind of thinking exhibited by addicts. (In fact, crime can easily be viewed as an addiction in that criminals exhibit seemingly uncontrollable, self-defeating, repetitious, immediately gratifying behaviors). Listed below are irrational beliefs often held by addicts (Ellis, et al, 1988; Daley, 1988). It takes only a slight application of "spin" to make them fully complementary to the irrational beliefs of criminals.

Demandingness - These are absolutistic demand statements made by criminals like *should, must, ought to, have to, need, require, command*. A criminal believes that he *deserves* respect, and that others *must* give him the attention, consideration, and financial rewards he is entitled to. These are unyielding, rigid, absolutistic requirements that allow no room for or acceptance of human fallibility. They are attempting to dictate their demands to the universe. Demandingness is unfounded, counterproductive, and irrational.

Awfulizing - When people evaluate events as awful, they magnify or exaggerate the badness of an event. *Awful* implies that the event could not be any worse than it is which, of course, it probably could be. If people accept the fact that bad things should be just as bad as they are because that is the way they indubitably are, they would usually stop their irrational awfulizing.

Low Frustration Tolerance - Criminals tend to believe that they "can't stand" the frustration and discomfort of responsible living. It may be hard or maybe even very hard, but is it really too hard to handle? Evaluating things as too hard places the criminal above the requirement of hard work and responsible living. Criminals LIKE what they do for a living. When the slow, responsible way becomes too hard, criminals will resort to crime. Suffering as the

responsible person knows it is foreign to a criminal (Yochelson and Samenow, 1977). Although he is willing to suffer the risks and pain of a prison sentence, he is unwilling to suffer as a responsible person might. To a rational human, pain is mandatory; suffering is not.

Magnification/Minimization - Criminals tend to minimize the good in their lives and magnify every little bad thing which happens to them. Rather than realistically viewing a situation they blow the situation out of proportion to the level of "badness." Criminals will say that they "need to steal to survive", "I'm a clone (sheep, sap, sucker) like you if I give up this criminal lifestyle", and "he shouldn't have taken my dime, so I hit him."

Black and White Thinking - The criminal sees things at either one extreme or the other. The criminal does not wish to understand that difficult periods are to be expected. The criminal may experience cravings or urges to return to the criminal "fast lane" and believe that he was not motivated at all, or that his treatment is "wearing off."

Selective Abstraction - Criminals are very good in pointing out their virtuous acts, their occasional nice deeds, and their artistic or musical talents. However, when compared against a lifetime of crime, these moments of niceness pale in the extreme. "...research clearly suggests that while lifestyle criminals are small in number, they account for a decisive majority of the serious crimes committed in this country" (Walters, 1990). On the other hand, criminals are VERY good at pointing out the mistakes and fallibilities of others.

Jumping to Conclusions - A criminal rarely problem solves well because to do so would, in his mind, let another person know that he did not know everything and because the answer received might not be the one he wishes to hear. The decisions he makes are designed to accentuate the exciting, to make lots of money quickly, and to build up his opinion of himself.

Should Statements - These create rules that negatively affect thoughts and behaviors. A criminal may tell himself that he "shouldn't get cravings, urges, or frustrations." The criminal may judge himself very harshly when he/she cannot live up to this rule. A criminal is very perfectionistic in those areas in which he chooses to be (Yochelson and Samenow, 1977).

Absolute Willpower Breakdown - Criminals assume that once willpower has failed, loss of control (continued criminality) is inevitable.

What criminals expect regarding the course of events after release from prison is crucial. Beliefs about the course of treatment outcome will play a significant role in determining the actual outcome. If criminal clients believe "parole is designed to make you fail, the system is against ex-cons, the world owes me a living, it's unfair not to own a gun," etc., then parole program

failure is assured. The criminal believes he has "no choice" but to go out and commit crimes. If, however, a criminal views a single criminal act as a slip or a lapse, and as an opportunity for new learning and personal growth (Marlatt, 1985), he will be less likely to relinquish control and give in to what this author calls "The Criminal Relapse."

The author is NOT condoning criminal activity. It is the author's belief that total abstinence from criminal activity is the only acceptable state of affairs. However, since the recidivism rate is approximately 66% and does not reflect those criminals who commit hundreds or thousands of additional crimes...and are not caught...perhaps a more realistic approach should be taken. The criterion for what constitutes a Criminal Slip, or Lapse for a criminal should be a lie, a small deception, a minor traffic violation, an instance of getting angry, irresponsible, or sneaky, and perhaps even an extremely minor misdemeanor. The "Emergency Reminder Card" feature of Relapse Prevention can also be applied after harmful felonious activity has occurred...but this author believes that the criminal should be allowed to practice his behavioral skills training and cognitive interventions from behind bars. The harm in some activities takes precedence over even enlightened treatment. In this same vein, a Relapse Prevention technique of "Programmed Relapse" would be inappropriate with criminals. It would not be a good idea for a criminal, under the therapist's guidance, to rob a bank and then later attempt to sort out his beliefs regarding this paradoxical intention technique.

If a Criminal Slip occurs, a criminal should refer to a common-sense Emergency Reminder Card for instructions. Marlatt's (1985) Coping Strategies Recommended in Case of Lapse list is designed mainly for drug users but is almost perfect, as is, for usage with criminals. This list is summarized below:

- 1.) Stop, look, and listen.
- 2.) Keep calm.
- 3.) Renew your commitment.
- 4.) Review the situation leading up to the lapse.
- 5.) Make an immediate plan for recovery.
- 6.) Ask for help.

There are many other useful Relapse Prevention techniques that can be utilized with criminals including education in the Abstinence Violation Effect, problem solving skills, self-monitoring, relaxation, balance and stress management training, and a description of past relapse episodes and future relapse fantasies.

Since therapists can no more change the world for depressed persons than they can for criminals, the only choice is for depressed persons and criminals to change themselves. Although the answer to the crime problem is as simple as humans not committing any more arrestable crimes, criminals rarely believe that and are disinclined to change themselves. Some researchers spend their

entire lives trying to remove the mantle of Personal Responsibility ("Isn't there a gene for crime?") from the shoulders of their all-too appreciative subjects. One wonders why Personal Responsibility and choice factors are abrogated in favor of misguided, although well-meaning, sociological or psychological claptrap? Parents know that a two year-old is fully capable of exercising free will. Why do we find it so difficult to believe adults are less capable of free choice? Why do we hold them to less stringent a standard than the two year-old? Two year-olds run away from their parents because they WANT to.

This author stated earlier that he cannot empirically PROVE the soundness and efficacy of RET and a cognitive, Relapse Prevention-based approach to criminality. What can be proved, ultimately? Very little. However, even if a person has facts or beliefs supporting the primacy of some outside influence, doesn't it make sense to live life as if Personal Responsibility and choice WERE paramount?

[The contents of this paper express the views of the author only and do not necessarily represent the official perspective of the Bureau of Prisons or the Department of Justice.]

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RELAPSE PREVENTION APPLIED TO
ASSAULTIVE OFFENDERS

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RELAPSE PREVENTION APPLIED TO ASSAULTIVE OFFENDERS

This paper, perhaps regrettably, represents speculation of a significant order. Ideas expressed lie along some ephemeral midpoint between phantasy and established fact; as this paper is being written the process of gathering data is in progress. No attempt is made to suggest that any feature merits codification as doctrine. Rather, these thoughts are offered in the interest of fostering dialogue and exchange about what presents as a significant and complex issue.

That assaultive offences are a serious social and legal problem is a statement of sophomoric proportion. In excess of 5.2 million incidents of criminal violence were reported in the United States in 1989, (Johnson & DeBerry, 1990). Approximately 6% of the Federal prison inmates are incarcerated for violent offences (Maguire & Flanagan, 1991) and 36% of the prison commitments reported for 36 states in 1986 were for violent offences. While sociologists and philosophers might have the luxury of contemplating about the root causes of these data, and admittedly there would be exemplary merit in identifying and mitigating the societal precipitants of violent offending, the treatment specialist is confronted with the need to formulate an intervention strategy that might prove efficacious in changing the offenders pattern of behavior.

An initial hypothesis we would offer for consideration is that assaultive offending does represent, for the majority of offenders, a dysfunctional behavior pattern. Very few of the offenders we encounter in the Directorate of Mental Health of the United States Disciplinary Barracks (USDB) could be characterized as remorseless psychopaths who have killed, maimed or assaulted with motivations that could be described as sadistic or pecuniary. Indeed, I would eliminate such individuals from consideration for the treatment program herein outlined. Review of "diaries" completed by participants in Assaultive Offenders groups at the USDB and the comments made in numerous individual and treatment group situations has led us to conclude that assaultive offences most typically appear to be situation specific responses accompanied by feelings of fear or panic in the face of danger real or imagined, undeniable or learned.

Clearly, such a formulation does not suggest that the offenders are hapless victims who have responded violently to one episode of threat in isolation. All inmates at the USDB were on active duty in one branch or another of the U.S. armed forces, hence virtually all of the individuals confined there

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are first time offenders. Despite this, however, most of the assaultive offenders we see in our institution have relatively rich histories as both victims and perpetrators of violence. They have learned that physical aggression can be an effective strategy for defending against perceived attack or influencing the outcome of interpersonal interaction.

Aggression, especially violent aggression, as an operant has many features that would sustain its conceptualization as a behavior pattern similar to that seen in substance abuse. The verbal reports of assaultive offenders of an "adrenaline rush" in anticipation of combat or physical conflict lends prima facie support for the idea that assaultive offenders are "addicted" to the physiological responses commonly described as the "flight or flight" reaction. Aggressive behavior, such as in defense of one's family or in time of war, is societally condoned in circumscribed instances; the parallel with social drinking is inescapable. Most importantly for the conceptualizing of aggression as a target of intervention, however, is its maintenance by contingencies on a readily identifiable gradient of reinforcement.

This last feature is exemplified by smoking tobacco as a model. Tobacco use has incontrovertibly negative long term consequences; cancer, emphysema, and coronary heart disease simply to list several of the most notable. Despite the undeniable fact that the long term consequences of tobacco use are consistently destructive, millions of Americans continue to smoke. Even in the face of increasingly widespread social condemnation, people continue to light up. While much can be made of the psychodynamics or psychopathology manifest in persistence in such a clearly self destructive behavior pattern, a reasonable discussion of smoking as a behavior would have to include mention of negative reinforcement as a salient feature of the contingencies extant. That is, when confronted by a noxious physical or emotional stimulus in the form of craving, urge or anxiety, the smoker responds with a behavioral strategy that immediately mitigates that unpleasant experience. Smokers cannot help but be aware of the mountains of evidence supporting the fact that their behavior, in the long term, is harmful if not patently suicidal. Immediate release from the grips of a present unpleasantness, however, offers more than escape from the possibility of slow asphyxiation in an undetermined future.

So to, the assaultive offender commits their offence in response to immediate contingencies, despite the fact that the long term result often includes loss of status, family, fortune, and freedom. Of course the denial that shields the substance abuser from confrontation of the negative contingencies inherent

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in their behavior works as well for the assaultive offender. Indeed, there is a modicum of statistical reality to the perpetrator's belief that they may escape detection or conviction if detected. But among the individual's we have interviewed at the USDB it seems that the possibility of punishment is rarely considered at the time of the event. Rather, the individual emits a response to stimuli at the time and usually does so without any formal cognitive analysis of alternative courses of action or even the awareness that alternatives to violent acting out exist at the time.

The Relapse Prevention (RP) model, with it's emphasis on identification of high risk situations and formulation of cognitive-behavioral coping strategies offers an ideal framework on which to build an intervention strategy. The RP with Assaultive Offenders approach currently evolving at the USDB has five key components which are outlined briefly in the following.

Phase I: Screening and Assessment:

Assaultive offenders, identified by adjudication or by institutional observation, must acknowledge responsibility for their offence and sign a contract to that effect. Further, they must acknowledge that the behavior for which they were sentenced was irrational to the extent that the end result of incarceration was not in their best interest. (Clearly, we hope that insight/awareness beyond this point develops in the course of treatment.) Inmates who maintain that their incarceration is unrelated to their behavior are excluded as are inmates who rigidly maintain their behavior was supportable and the exclusively appropriate course of action. Also excluded are those few inmates manifesting gross thought disorder. Candidates must have participated in previous group therapy.

Assessment instrument used in an attempt to quantify changes made in the course of group involvement are currently being revised, developed, or standardized. For the most part they are available in the public domain. Pre/post tests and inventories include the following: Attitudes Toward Violence Scale (adapted from Velicer, Huckel, and Hansen, 1989); Buss-Durkee Hostility Inventory, (Buss and Durkee, 1957); Assaultive Offender's Situational Competency Test (adapted from Miner, Day, and Nafpaktitis, 1988); Internal/External Locus of Control Scale (Nowicki, 1974); and Anger Inventory, (Novaaco, 1975).

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Phase II: Introduction:

This represents an introduction both to RP as a concept and, even more importantly, as an orientation to the group process. Since all participants of the Assaultive Offenders groups have previously been involved in other group therapy, neither the basic concept nor expectations for group members are new. We do employ a "Constructive Participation Scale", however, to rate each group member's participation on a five point Likert scale. Participants are informed of this and criteria for constructive participation are identified. Lack of constructive participation constitutes grounds for termination from the group.

A structured autobiography is assigned in this session. This is reviewed by the therapists later and areas for expansion by the participant are identified. The autobiography will be referred to at various points throughout the course of the group.

Phase III: Didactic Instruction and Skills Training:

Topics in lecture, discussion, and film when appropriate

"Unique" to Assaultive Offenders

- Biopsychosocial model of aggression
- Child development
- Role of alcohol in aggression

Borrowed from Relapse Prevention

- Elements of High Risk Situations
- Decision making (Relevant and Apparently Irrelevant)
- Problem of Immediate Gratification
- Coping strategies
 - Anticipation and Rehearsal
 - Rational Thinking
 - Assertive Communication
 - Stress Management

Phase IV: Individual Presentations:

Each individual discusses their confining offense and analyzes that event in terms of the RP model. Individual history is shared to the extent that it explains developmental and historical precipitants for assaultive offending. Presentations are made in a "hot seat" format. Usually, one inmate presents per session.

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Phase V: Assessment and Feedback:

The same battery of assessment instruments as comprised the pretest is administered. The results are interpreted and individual feedback is given to each participant.

It is important to underscore the speculative nature of this presentation. As this paper is written the first iteration of an Assaultive Offenders group to formally incorporate all these elements in a structured fashion is in progress. Most of the individual elements in one fashion or another have been used previously in Assaultive Offenders and/or other groups offered within the Directorate of Mental Health. We have the mechanisms in place to track the progress of graduates within the institution and that will be done, but as yet there are no data available to support the hypothesis that treatment of assaultive offenders has any impact either positive or negative. We are limited in the ability to track the progress of individuals once they leave the Disciplinary Barracks since individuals confined there, with very few exceptions, no longer have any contact with the U.S. military.

We feel the approach presented does have merit, however. Guided by the data that suggest cognitive-behavioral intervention can be very effective for address of a wide range of dysfunctional behavior patterns and firm in our belief that the conceptualization of violent offending represents a valid construct, we move on. We welcome the use of the ideas or instruments herein described by others and would appreciate any feedback generated as a result.

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**COMPULSIVE GAMBLING: ISSUES
IN A CORRECTIONAL SETTING**

by

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Pathological gambling, more commonly referred to as "compulsive gambling," is a psychiatric disorder (American Psychiatric Association, DSM IIIR, Section 312.31) which is rapidly increasing in all segments of society. In the mid 1970s less than .77% of the adult population were suffering from this psychological addiction. Most of the compulsive gamblers who then attended Gamblers Anonymous meetings were white, middle-aged businessmen who typically committed crimes such as fraud, forgery, or embezzlement. However, as the movement to legalize many new forms of gambling expanded across the country, making gambling readily accessible and available to all, the profile of the compulsive gambler changed accordingly.

Today a compulsive gambler may be male or female (approximately 25% are female), come from any socio-economic level, any educational level, and all age, religious, ethnic, and occupational groups. Current research suggests that over 3% of the adult population and over 5% of the adolescent population in the United States today could be considered pathological gamblers.

Not surprisingly, then, the types of crimes committed today vary accordingly. While businessmen, accountants, stock brokers and lawyers most typically still resort to mail fraud, embezzling company funds or violating their fiduciary trust by using clients accounts to support their gambling addiction, other compulsive gamblers are now resorting to a variety of bad check charges, such as writing checks against insufficient funds, on a closed or family member's account, or kiting or floating checks. Credit card violations abound, and it is not unusual for a compulsive gambler to have twenty or more credit cards, all of which have been charged to the limit to support the gambling addiction.

Other financial, non-violent crimes are also seen more frequently today, such as bookmaking, tax fraud or evasion, robbery (almost always with a non-functional weapon), or selling drugs. Adolescents most often start by stealing monies from parents and family members.

The offenses tend to be committed repeatedly, for as long as the gambling addict is in the out-of-control phase of the illness. One banker, for instance, acquired cash to support his casino addiction by setting up false loan accounts, "borrowing" and repaying for several years; a landscaper wrote hundreds of bad checks throughout his state in a one-year manic phase, to buy lottery tickets; a concert ticket seller used clients' credit cards for two years to support his race track addiction, and a female bookkeeper skimmed funds for several years to support her poker machine habit.

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Yet virtually all compulsive gamblers led honest, law abiding lives prior to developing their gambling addiction. Of those who face legal charges (approximately 25%), most fail to realize that they are suffering from a psychiatric disorder, rationalizing that they were "on a losing streak, and the next bet would be the big win with which to pay back what had been borrowed." How, then, can mental health counselors in correctional settings, help these offenders?

Types of Gamblers

Not all gamblers are compulsive gamblers. Most are *social gamblers*, individuals who gamble for recreation and who set limits on the amount of money, frequency, and time spent on gambling. Losses are viewed as the cost of entertainment or leisure time.

Professional gamblers earn their livelihood from financial risk-taking, such as stock brokers or casino personnel. They view their gambling as a business, in which gambling wins and losses are carefully analyzed, and which does not interfere with personal, family and other pursuits.

The *criminal gamblers*, which are often seen in penal institutions, tend to have a history of anti-social behavior involving many types of criminal activity, including illegal gambling, swindling, racketeering, and loansharking.

Pathological gamblers virtually always are above average in intelligence, very competitive, and highly motivated to achieve. They have a solid set of values concerning law and order, family, health, job, and the community. Unfortunately, their families of origin are dysfunctional, with patterns of parental alcoholism or compulsive gambling, parental absence or emotional deprivation, lack of nurturance, ineffective communication, and a variety of abuse - physical, verbal, psychological and/or sexual. There is a strong emphasis on money.

The future compulsive gambler grows up with a severe lack of emotional development, few coping skills, low frustration tolerance, and virtually no self-esteem. Fear of criticism and rejection lead to isolation and becoming a "loner." Feelings associated with traumatic events and losses are repressed, leading to dysthymia. They seek acceptance and recognition through accomplishments, becoming star athletes and outstanding employees.

Exposure to gambling, often associated with early wins, is initially viewed as a fun activity, a chance to exercise competitive skills to obtain a commodity valued in the family and community, money. Unfortunately, traumatic events occur, such as an injury which prevents further athletic goals,

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the loss of a loved one, or the betrayal from an employer. Unable to cope with these stressors, the person seeks escape from his painful reality through extended gambling. Gambling becomes chronic and progressive, and tolerance levels require larger amounts of money. Losses are intolerable for these very competitive people, and eventually lead to reckless chasing. When legal access to funds are exhausted, the gambling addict will now resort to illegal activities. In the course of the addiction, the gambling addict will experience a host of severe psychosomatic symptoms, major depression on top of the dysthymic depression, anxiety disorders, and is at high risk of suicide.

Treatment Considerations

Compulsive gamblers do not fare well in prison settings. They lack the experience of the street-wise person, they view themselves as very different from other offenders, they have had very little, if any, prior experience with prisons and are terrified of the environment and potential dangers. Most importantly, now, they can no longer escape their painful reality, and come face to face not only with their traumatic past, but also with their gambling-related activities, such as their illegal activities, neglecting their families, lies, debts, guilt and humiliation.

They may desire to stop gambling, but recognize very quickly that gambling prevails among offenders and corrections officials, which puts further stress on the gambler. They may seek help, only to find that help is very limited. Counselors are either overburdened with their case loads, or know very little about compulsive gambling.

Certainly with any identified compulsive gambler, an immediate psychological assessment is indicated to determine the level of depression, anxiety, potential for suicide, and the need for medication and psychotherapy.

Group therapy is ineffective with compulsive gamblers, other than at a surface level, such as a group on honesty or on addictions education, because these addicts have a strong need for control and acceptance, do not trust, and to talk about feelings means to process unresolved traumas in a hostile environment, among strangers. This would leave them too vulnerable emotionally.

A penal institution may have the option of permitting a chapter of Gamblers Anonymous to be established on its site. In reality, however, prison officials have resisted allowing "yet another self-help group" in their institutions, and few outside GA members are willing to divulge their identity, making entrance into the institution impossible.

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Turn-over rate of offenders and prison counselors also complicate any efforts at establishing self-help or professional therapy within the institution, especially since many of these offenders are not aware they are suffering from compulsive gambling and do not seek out such support.

Institutions do have some options, which tend, though, to be costly and less than practical. One is to increase the number of mental health counselors within an institution. These counselors will then need to be trained in diagnosing and treating compulsive gamblers.

Another is to identify specific institutions within the state, federal, or military correctional system, to which all compulsive gamblers could be sent, thereby minimizing the need for gambling-trained counselors, while also producing a more supportive therapeutic climate.

Prison officials will need to evaluate their own policies with respect to gambling among staff and offenders. While gambling in prison serves a useful function for most offenders, such as avoiding boredom and interpersonal tensions, it can also lead to increased tension among inmates who lose, and illegal activities among compulsive gamblers, whether these are staff or inmates.

Finally, prisons can expand their libraries to include materials on compulsive gambling.

Alternative Options

Compulsive gambling is a treatable disorder. Short-term intensive therapy using a comprehensive treatment team, appears to have long-term positive results. Treatment would focus on resolution of traumas, teaching effective coping and communication skills, identifying stressors which lead to gambling urges, and developing a strong support system, both within the family and with Gamblers Anonymous. Restitution is always an integral component of treatment.

These goals cannot be accomplished within a closed correctional setting. They can be initiated within other settings, such as a pre-release center or half-way house, although with limits due to constraints of the setting.

A more realistic approach to prevent relapses of compulsive gambling and recidivism into criminal activity, then, is to emphasize treatment for the disorder, both professional and self-help group, restitution over time, and community service for the duration of probation.

In this manner the gambling addict is able to overcome personal shortcomings, maintain abstinence from gambling, and take full responsibility for conduct resulting from the illness.

PATHOLOGICAL GAMBLING: CO- AND CROSS ADDICTIONS,
CO-MORBIDITY, AND PERSONALITY CHARACTERISTICS

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An In-Patient Mental Health Unit
within a
State Correctional Center
for
Female Offenders

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An In-Patient Mental Health Unit

within a

State Correctional Center

for Female Offenders

Dwight Correctional Center is the reception and classification center and primary state prison for female offenders incarcerated in Illinois. The Dwight facility is operated by the Illinois Department of Corrections.

History of the Mental Health Unit

In 1976, the Administration of the Dwight Correctional Center initiated a study and proposal for the development of a Mental Health Unit at the facility. This project, dated October 5, 1976, proposed that a separate unit be established within the facility to provide mental health services. At that time, an administration with an accurate perception of future needs, recognized that, as the female population increased, there would be an increased need for mental health services.

The separate unit began on September 1, 1977, with an eight-bed capacity in-patient unit located on a wing of an existing housing unit. The first offender was admitted on October of 1977 and by December all beds were occupied. The original staff consisted of a correctional counselor, a nurse and a recreation worker. In May of 1978, an activity therapist, correctional therapy worker and another correctional counselor were added to the staff.

Programs offered in the unit included individual and crisis counseling, group therapy, and a reception and a reception and classification group. Additional projects and programs were initiated after more staff were added. These programs included interpersonal communication skills, relaxation groups, human development group, substance abuse counseling, Alcoholics Anonymous, and a special gardening project.

In October of 1979, the Mental Health Unit was moved to a different building in the institution and emphasis was placed on day treatment programming, primarily emphasizing individual and group counseling.

The program was re-evaluated and again moved in May of 1980. The staffing pattern was revised to include a psychologist as administrator of the unit, a social worker, two correctional counselors and psychiatric services. Records procedures and documentation of treatment were revised and formalized. A Policies and Procedures Manual was developed. The in-patient portion of the program was expanded to a thirteen bed capacity building and the continued day treatment programming of the unit provided expanded services to an increasing female offender population.

Due to the continued increase of the number of offenders at the Dwight facility, the administration responded to the corresponding need for mental health services. In 1982, plans were started to construct a new forty-six bed in-patient mental health unit which expand the capabilities of the unit as well as improved the safety and security of the physical structure. After months of work and construction, the Mental Health Unit was moved into a new K-shaped unit on December 20, 1984.

Programming and services were divided into areas in the four wings of the new building. Special care, located on a twelve-bed wing, provided intensive services for inmates with the most severe or acute problems, such as severely disorganized psychotics, inmates with the need for special watches due to suicidal behavior, and aggressive inmates. Intermediate care was located on an eleven-bed wing and provided continued care for moderately severe mental health problems. Supportive services was located on two wings with a total bed capacity of twenty-three. This area provided services for less severe problems and more stable inmates.

Program Statement

The Mental Health Unit at the Dwight Correctional Center provides comprehensive mental health care for those inmates at the facility who are experiencing mental health problems. Services offered include individual and group counseling, psychology, supportive counseling, psychiatric services, psychotropic medication, and psychiatric and psychological evaluations.

Current Staff

Current staff includes a psychologist administrator, two psychologists, two correctional counselors, an office assistant, and thirty hours per week of psychiatric services under contract with Prison Health Services.

In addition to the clinical staff, there are three correctional officers assigned on each of three work shifts.

Correctional Officer Utilization and Training

Recognizing that the offenders assigned to the Mental Health Unit have frequent and prolonged contact with the correctional officers and also that the correctional officers are the only staff on duty during large parts of the day, officers are advised of programming as much as possible. Correctional officers are provided with annual training as part of the routine mandatory training of all staff. This training includes a review of special programming responsibilities and special watches. The correctional officer is perceived as an integral part of the treatment team, and since security and operational aspects of daily life in a correctional center have a great impact on behavior of the offenders, the correctional officer must be involved in program implementation.

Admission Criteria and Procedures

A female offender may be admitted to the Mental Health Unit if, after an evaluation, the psychiatrist recommends admission. The inmate then may agree to placement in the unit or she may disagree and request a formal hearing.

If an offender requests a hearing, the Psychiatric Review Committee must hold a hearing within five working days. The Committee is composed of one staff member from Clinical Services, one administrator or supervisor,

such as Clinical Services Supervisor or Assistant Warden of Programs, and one person not employed by the Illinois Department of Corrections. The Committee decides by majority vote whether or not the inmate is to be admitted. Inmates may have witnesses called, may have an independent psychiatric evaluation, and may appear at the hearing.

An offender is admitted on an emergency basis pending a hearing if the psychiatrist believes that the inmate is reasonably expected, at the time of the evaluation or within a reasonable time thereafter, to intentionally or unintentionally physically injure herself or others, or is unable to care for herself so as to guard herself from physical injury or to provide for her own physical needs.

Review of Admitted Offenders

Once every six months, an offender who is continued in the Mental Health Unit may request a hearing to determine whether or not she should remain placed in the unit. In these cases, the offender receives a hearing before the Placement Review Board. The Placement Review Board is composed of three members, one of whom is a mental health professional and one of whom is a lay person. No more than one member of the Board may be in the employment of the Dwight Correctional Center. The Board may decide whether or not an offender should remain in the Mental Health Unit or be returned to the Dwight general population.

Special Watches

Special watches may be initiated when an offender is suicidal,

aggressive, or exhibiting problematic behavior.

There are for special conditions. Therapeutic restraints may be utilized as a last resort to control an offender and prevent injury. Therapeutic restraints may be ordered by a psychiatrist, or by a physician in an emergency. A special watch every ten minutes is completed by the correctional officer. Suicide watch requires a ten minute observation and this status may be initiated by a psychiatrist or other mental health professional. Close supervision requires an observation of the offender every fifteen minutes and it may be ordered by a mental health professional. Mental health observation requires a thirty minute check. Mental health observation may be started by a mental health professional.

There are currently an average of seventeen special watch incidents per month. Therapeutic restraints are used infrequently and the most commonly utilized special watches are suicide watch and close supervision.

Crisis Intervention

The Mental Health Unit operates a crisis intervention team which serves the entire institution population. The team is composed of counseling, security, health care as well as staff from other institutional areas, for example an educator and a corrections food supervisor. The team members complete a special training program at the Illinois Department of Corrections Training Academy. Training includes response to crisis, identification of mental health problems, and significant issues related to crisis situations of the correctional setting. The

Dwight team also meets quarterly to review all special watch incidents and crisis intervention team responses. In addition, in-service training is conducted each quarter on different, relevant crisis intervention and mental health issues.

There are an average of twelve crisis intervention team responses each month. Most crisis responses are precipitated by some unusual incident or situation encountered by the concerned offender, such as a death or illness of a family member, problems with children or family in the free community, and institutional adjustment or disciplinary problems. Most of the crisis intervention team responses occur on the 3:00 P.M. to 11:00 P.M. shift.

Admissions Data

During calendar year 1991, there were 32 admissions to the Mental Health Unit. The average age of the offenders admitted was 30.8 years. Racial breakdown indicated that 46% were white and 54% were black. Average number of years of education was 10. Fifty-four percent of the inmates were from Cook County (Chicago) and 46% were from the other 101 counties of Illinois. Twenty-eight percent were readmissions to the unit, and 59% had previous in-patient treatment prior to admission to the Dwight Correctional Center. Average sentence was 5.6 years. Fifty-six percent had a history of suicide attempts.

Data for the past years of admissions for the Mental Health Unit indicate a fairly consistent pattern compared to the data for 1991. The average age

was 29.5 years. Racial breakdown was 51.4% black, 48.4% white, and 0.2% Hispanic. Average years of education was 10.3. Cook County (Chicago) provided 53.8% of the offenders and 46.2% of the offenders came from the other counties. Readmissions to the unit accounted for 16.6% with 56.4% having previous in-patient mental health care prior to admission to Dwight. The average sentence was 7.1 years. History of suicide attempts included 49.6% of the admissions.

Rather than including diagnosis in the data, information by admission symptoms and/or problem behavior are included. For 1991, these symptoms and corresponding percentages of offenders were hallucinations (11%), delusions (11%), depression (19%), suicidal ideation (17%), suicide attempt (11%), anxiety (13%), hostility/aggressive behavior (12%), and withdrawal (6%).

Use of Psychotropic Medication

Enforced medication procedures were revised following the recent Supreme Court decision. Offenders must be approved by the Treatment Review Committee before medication can be given against an offender's wishes. The Treatment Review Committee is composed of two mental health professionals, one of whom must be a physician.

Before ordering enforced medication, the treating psychiatrist must evaluate the offender and determine that she suffers from a mental illness, that the medication is in the medical interest of the offender, and that the offender is either gravely disabled or poses a likelihood of serious harm to herself or other.

The Treatment Review Committee must decide whether or not the medication is to be given. If the offender appeals the decision, the case is referred to the agency Medical Director who will make a decision.

Every six months, an offender who has been involuntarily receiving psychotropic medication can request a review of the medication order to be conducted by the Treatment Review Committee.

Under the provisions of the established guidelines and procedures for enforced medication, gravely disabled means a condition in which an offender, as a result of a mental illness, is in danger of serious physical harm resulting from her failure to provide for her essential human needs of health or safety, or manifests serious deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over her actions which is likely to seriously jeopardize her health or safety. Likelihood of serious harm means a substantial risk that physical harm will be inflicted by an offender upon her own person as evidenced by threats or attempts to commit suicide or inflict physical harm on herself; or a substantial risk that physical harm will be inflicted by an offender upon another person as evidenced by behavior which has caused harm or which places another person in reasonable fear of sustaining harm. Also, there could be a substantial risk that physical harm will be inflicted by an inmate upon the property of others as evidenced by significant loss or damage to the property of others.

Guilty But Mentally Ill Offenders

Under Illinois statutes, offenders may be found to be Guilty But Mentally Ill and sentenced to the Illinois Department of Corrections. These offenders are placed based upon their need for mental health services and are not mandated by the statute to be in the Mental Health Unit. Of the current Guilty But Mentally Ill offenders, 50% are placed in the Mental Health Unit while the remainder are in the general population at Dwight or another correctional institution.

Major Challenges

The biggest challenge of an in-patient unit in a correctional facility is to maintain a therapeutic, supportive milieu and still maintain the security rules of the correctional facility. It is often difficult to balance treatment needs, particularly for severely disturbed offenders, within the structure of the institution.

A second challenge is to maintain delivery of services to all offenders by utilizing other areas of the facility. For example, the Mental Health Unit must rely upon the school for classes and educational programming, the central dining facility for meals, a separate recreation department for leisure services, and other areas for work assignments.

Another significant challenge is to maintain adequate staff. Qualified mental health staff are difficult to find to work in the correctional setting.

DWIGHT MENTAL HEALTH UNIT

ADMISSIONS 1991

AGE, RACE, EDUCATION, COUNTY AND MENTAL HEALTH HISTORY

Average Age: 30.8 years

Race:	White	46%
	Black	54%
	Hispanic	0%
	Other	0%

Average Education: 10.0 years

County:	Cook	54%
	Other	46%

Previous Dwight Mental Health Unit: 28%

Previous In-Patient Mental Health: 59%

History of Suicide Attempts: 56%

Average Sentence: 5.6 years

DWIGHT MENTAL HEALTH UNIT

ADMISSIONS 1991

<u>ADMISSION SYMPTOMS</u>	<u>NUMBER</u>	<u>PERCENTAGE</u>
Hallucinations	9	11%
Delusions	9	11%
Depression	16	19%
Suicidal Ideation	14	17%
Suicide Attempt	9	11%
Anxiety	11	13%
Hostility, Aggression	10	12%
Withdrawal	5	6%
Total*	83	100%

*All inmates had multiple symptoms.

DWIGHT MENTAL HEALTH UNIT

ADMISSIONS

PAST 5 YEARS

AGE, RACE, EDUCATION, COUNTY AND MENTAL HEALTH HISTORY

	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>5 YEAR AVG.</u>
Average Age:	33.1	27.7	26.2	29.9	30.8	29.5 years
Race: Black	51%	55%	37%	60%	54%	51.4%
White	48%	45%	63%	40%	46%	48.4%
Hispanic	1%	0%	0%	0%	0%	0.2%
Other	0%	0%	0%	0%	0%	0.0%
Average Educations:	10.1	9.9	11.1	10.5	10.0	10.3%
County: Cook	47%	66%	52%	50%	54%	53.8%
Other	53%	34%	48%	50%	46%	46.2%
Previous DMHU:	29%	26%	26%	.07%	28%	16.6%
Previous In-Patient	53%	66%	53%	51%	59%	56.4%
History of Suicide Attempts:	38%	52%	63%	39%	56%	49.6%
Average Sentence:	5.8	9.9	7.1	7.0	5.6	7.1 years

DWIGHT MENTAL HEALTH UNIT

ADMISSIONS 1991

<u>MONTH</u>	<u>ADMISSIONS</u>	<u>EMERGENCY</u>	<u>FROM R & C</u>	<u>FROM GEN. POP.</u>	<u>TRANSFERS</u>
January	3	0	1	2	0
February	3	0	1	2	0
March	4	0	4	0	0
April	1	0	0	1	0
May	4	0	3	1	0
June	5	0	1	4	0
July	4	0	0	4	0
August	1	0	1	0	0
September	3	0	1	2	0
October	2	0	1	1	0
November	0	0	0	0	0
December	<u>2</u>	<u>0</u>	<u>0</u>	<u>2</u>	<u>0</u>
Total	32	0	13	19	0

DWIGHT MENTAL HEALTH UNIT

PROGRAM STATISTICS 1991

<u>MONTH</u>	<u>PSYCHIATRIC EVALUATIONS</u>	<u>PSYCHOLOGICAL EVALUATIONS</u>	<u>THERAPY CONTACTS</u>	<u>COUNSELING CONTACTS</u>	<u>MONTHLY TOTAL</u>	<u>MONTHLY AVERAGE</u>
January	136	435	138	138	847	212
February	213	401	98	169	881	220
March	250	449	114	138	951	238
April	148	423	101	140	812	203
May	136	618	198	153	1105	276
June	173	512	94	144	923	231
July	101	455	116	114	786	197
August	159	633	134	124	1050	263
September	191	457	91	109	848	212
October	190	647	163	169	1169	292
November	191	410	177	159	937	234
December	144	209	154	187	694	173
Category Total:	2032	5649	1578	1744	Grand Total:	11,003
Category Average:	169	471	131	145	Monthly Total Average:	917

STATEWIDE MENTAL HEALTH SERVICES IN THE OKLAHOMA DOC:
AS BALANCE OF CENTRALIZED AND OUTREACH ACTIVITY

BY

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&

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OKLAHOMA DEPARTMENT OF CORRECTIONS

MENTAL HEALTH UNIT

LEXINGTON, OKLAHOMA

Statewide Mental Health Services in the Oklahoma DOC:

A Balance of Centralized and Outreach Activity

by

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Every state department of corrections has developed programs for providing mental health services to offenders. These programs are often a multi-agency patchwork created over time in response to political, social, geographical, and budgetary forces. This presentation describes the strategies that have evolved in the Oklahoma Department of Corrections (DOC): their origins, pitfalls, strengths and weaknesses, and proposed improvements.

The Oklahoma DOC has over 13,150 offenders in 15 prisons, 8 community correctional centers, and 10 work-release camps in locations scattered throughout the state. Inmates who need inpatient mental health treatment are transferred to a centrally located, 85 bed Mental Health Unit (MHU) at an 800 bed medium security prison. The MHU opened in January 1982 in response to a federal court order and its staff of 36, including a full-time psychiatrist, are all DOC employees.

The MHU psychiatrist and four part-time psychiatrists provide on-site consultation and evaluation at all of the prisons and CCCs. Most of the prisons also have a full-time psychologist for ongoing therapy and follow-up. One of the RN positions at the MHU is for outreach, and several of the nurses are travelling to remote facilities for additional follow-up.

The outreach (on-site) program has several purposes:

1. Follow-up of inmates discharged from the MHU.
2. Medication reviews for all inmates on psychotropics.
3. Screening of inmates for new mental health treatment programs or for admission to the MHU.
4. Formal and informal training of DOC staff scattered throughout the state.
5. Psychiatric evaluations for special purposes, such as risk of community placement of HIV-positive inmates, or medicating psychotic inmates on death row.
6. Public relations! The MHU serves correctional facilities in the entire state; the personal contact of the outreach program creates respect and understanding between employees, including security staff.

New challenges have been identified.

1. Designing a 50 bed chronic Special Needs Unit at a maximum security prison.
2. Implementing small on-site MHUs for female and death row inmates.
3. Expanding MHU participation in DOC preservice and inservice training programs.
4. Computerization of MHU patient contacts, for follow-up and research. MHU programs now reach over ten percent of the DOC population and computers are no longer optional.
5. Establishing preceptorships and traineeships for mental health professionals. Such programs assist patient care, as well as recruiting.
6. Counseling program for HIV-positive inmates. Oklahoma is one of 19 states that has mandatory HIV testing at intake. The MHU, in collaboration with the Assessment and Reception Center, has established a counseling program for newly identified HIV-positive inmates. These inmates will be treated throughout their incarceration with the help of the existing MHU Outreach Programs.

OKLAHOMA
DEPARTMENT OF CORRECTIONS

4,200 Employees

15 Prisons
7 Probation & Parole Districts
8 Community Correctional Centers
10 Inmate Work Centers

13,150 Inmates
4,150 Parolees
25,500 Probationers

The 85 Bed MHU

12-18 ACUTE, Single Cell
0-2 5-Point Restraint
25-30 SUBACUTE, Single/Double
38-40 CHRONIC, Single Cell

ADVANTAGES OF MHU OUTREACH

Improved Staff Training
Better Staff Morale
Continuity of Care

Cost-effective

SYSTEM WIDE!

STAFF OF THE MHU

1 Psychiatrist-Clinical Director
1 Health Services Administrator

3 Psychologists
1 Social Worker
1 Recreational Therapist
1 Psychiatrist [Part-time]
1 Physician Assistant

2 Case Managers
1 Medical Records Supervisor
1 Secretary

13 Correctional Staff
11 Nursing Staff

PURPOSES OF MHU OUTREACH

Follow-up MHU Dischargees

Review All Inmates on Psychotropic
Medications

Screenings for MHU Admission

PURPOSES OF MHU OUTREACH

Evaluation for DOC Programs

Special Evaluations
Death Row
HIV-Disease

Training DOC Staff
Formal: Preservice, Inservice
Informal

PURPOSES OF MHU OUTREACH

Intra-agency Outreach
Special Needs Unit
Computerization
Pharmacy Committee

Inter-agency Outreach
Mental Health
Substance Abuse Services
Public Health

Community Outreach
Schools
Traineeships
Alliance for Mentally Ill

LONG-TERM MENTAL STABILITY

Need Support Systems

Need Continuity of Care

Need Consistent Staffing

Need Satellite Special Needs Units

RELAPSE PREVENTION
with
INPATIENT INTERVENTIONS

by

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Extended Mental Health Care in Prisons-Panel Presentation

Relapse prevention for psychiatric patients begins while the patient is still an inpatient. The Mental Health Unit admits inmates who are psychotic or experiencing some sort of crisis. Once the crisis is resolved or the psychosis responds to medication, the MHU inmates are frequently still disabled by secondary effects of mental illness and psychological deficits which prevent their functioning adequately in the general prison population.

Most of us have heard at one time or another, "He/she looks like a mental patient." This is so because many patients fail to maintain acceptable personal hygiene. They appear sloppy and dirty. They also appear emotionally flat, aloof, and preoccupied. In our prison system we hear, "he can't, won't hold a job," "He's in the pill line every night," and "He spooks his cellmate."

The inmate who does not "fit in" is much more likely to experience relapse than the inmate who is functioning appropriately when he is first returned to the general population. ^{Relapse}Relapse prevention begins by being sure that patients have acquired the skills necessary not only to survive but also to behave acceptably in the general prison population. A major undertaking.

Many of our interventions, originally intended to ease adjustment to the general population, i.e. prevent relapse, have had some other very positive effects. We do not intend to devote any time to theory but rather give you a list of problems together with our solutions and to mention briefly some of the benefits. Our solutions can be roughly divided into two types of interventions: Management Techniques and Program Groups.

Management

1. Injections: vs daily BID, QID pill lines
 - improves compliance
 - raises staff consciousness of compliance
 2. Coupons and daily rounds
 - clean unit
 - DOC dress and grooming code enforced
 - daily checks and twice weekly coupon exchange increases staff time with inmates
 - scheduled wake-up and rounds time decreases the number of sleep disturbances
 3. Pet Therapy
 - allows expression of feelings of affection
 - teaches responsibility
 - provides mutual interests
 4. Discharge Criteria
 - double-celled
 - working
 - pre-release group
- assure inmate's behavior meets DOC standards for Earned Credit Level II

Program

1. Pre-Release Group:
 - provides information relevent to functioning in the general prison population
 - subject matter (misconducts: types and consequences, parole process, inmate slang, inmate rights, etc.) may not be novel but the psychology assistant and social worker use a Jeopardy game format to make it fun and
 - learning does not occur unless students are emotionally involved
2. Reminiscent Group
 - your life's worthwhile
 - recalling and sharing is fun
 - socializing
 - appropriate self-revelation
3. Current Events
 - your not the only fish in the sea
4. Humor Group
 - it's all right to have fun
 - assessment
 - staff enjoys preparation
 - laughter is the best medicine NIMH says smiles literally make you feel better
5. Friday Functions
 - vs. Friday Freights
 - broaden interests and experiences
 - increased staff availability at a crucial time

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REDEFINING BOUNDARIES OF MENTAL HEALTH SERVICES:
A HOLISTIC APPROACH TO IMPROVING THE MENTAL HEALTH OF INMATES

BY

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SCHOOL OF SOCIAL WORK

Redefining the Boundaries of Mental Health Services:
A Holistic Approach to Improving the Mental Health of Inmates

Presentation at the
2nd Annual Midwestern Mental Health in Corrections Symposium
May 28, 1992

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Louisiana State University, School of Social Work

Outline of Paper Presentation

- I. Introduction (Brief review of professional and legal writings which delineate mental health treatment with prisoners).
 - A. Review of the literature
Types of treatment programs offered in prisons.
 - i. Therapeutic communities
 - ii. Substance abuse
 - iii. Sex offender treatment
 - iv. "Generic" therapy
 - B. Professional standards related to mental health
 - i. American Correctional Association
 - ii. National Commission on Correctional Health Care
 - C. Legal mandates for prison mental health programs
 - i. Landmark cases from the 1970's and 1980's
Estelle v. Gamble, 429 U.S. 97 (1976):
Established the "deliberate indifference to serious medical needs" standard under the eighth amendment.
 - ii. Recent United States Supreme Court decisions:
Wilson v. Seiter, 59 USLW 4671 (1991):
The element of intent as related to the standard of deliberate indifference.
Ruf v. Inmates of Suffolk County Jail, 60 USLW 4101 (1992): Related to modifications of consent decrees in pre-trial detention facilities.
 - iii. Important messages from the lower courts

Newman v. Alabama, 559 F.2d 283 (5th Cir. 1977).: failure to provide inmates with basic medical care, including mental health care, would deprive the prisoner of his/her constitutional rights under the eight amendment.

Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977).: "we see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart"

Hayes Williams v. Edwards, 547 F.2d 1206 (5th Cir. 1977). Related to conditions at Angola State Penitentiary.

Ramos v. Lamm, 639 F.2d 559 (10th Cir. 1980). Colorado's prison reform case.

Pugh v. Locke, 406 F.Supp. 318 (M.D. Ala. 1976). Ordering a classification system be created in the Alabama system. Ordering mental health staffing ratios in the Alabama system.

Greason v. Kemp, 891 F.2d 829 (11th Cir. 1990)

- D. What's missing?
 - i. Interaction with other prisoner services
 - ii. Cooperative services offered to prisoners (and staff) from non-traditional sources
- A holistic approach?
 - i. A broad definition of mental health services (make mental health staff more useful in the institution)
 - ii. Treating the whole person/prisoner

II. Working in a "Hosted" Setting

- A. Security as the primary concern of prison management
- B. Mental health professionals=secondary agents
- C. Creating an indispensable mental health division

III. Ten Categories of Services Impacting the Delivery of Mental Health/Mental Health-Related Intervention

- A. Written communication/oral person-to-person communication: external agencies; other institutional divisions; grass-roots organizations**
- B. Medical Services: sharing information, revisiting confidentiality**
- C. Environment: lighting, colors, interview rooms**
- D. Training: staff and inmates--mental health and mental health related issues. Appeal to the "hidden therapist"**
- E. Education: for employees**
- F. Classification: dual check systems on mental health**
- G. Work/academic/vocational programming for prisoners: keep them busy...**
- H. Visitation**
- I. Employee counseling: set aside a day**
- J. Administrative duties: more than shuffling paperwork**

IV. Assessing the direction of mental health services.

- A. How often does your phone ring?**
- B. Who's on first? (management)**
- C. Policies in order?**

V. Conclusions

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HURDLES TO THE IMPLEMENTATION OF TREATMENT PROGRAMS
IN CORRECTIONAL SETTINGS: A CONSTRUCTIVIT'S RUMINATIONS
FROM A MAXIMUM SECURITY PRISON

BY

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HURDLES TO THE IMPLEMENTATION OF TREATMENT PROGRAMS IN CORRECTIONAL
SETTINGS: A CONSTRUCTIVIST'S RUMINATIONS FROM A MAXIMUM SECURITY PRISON

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THE PROBLEM

The cornerstone of successful mental health treatment is a positive therapeutic relationship. This relationship is the cornerstone for all treatment modalities (e.g., the different types of individual, group, couple's, and family therapies). In order for patients to effectively work with their therapist, they must respect and trust their therapist. Likewise, for therapists to effectively work with their patients, they must be free of counter-transference "baggage." This mutual respect and trust constitutes the fundamental building blocks of mental health treatment.

Within free society, these conditions for therapy are usually met or therapy is discontinued. Patients who are usually motivated for help, search for a therapist whom they can trust and respect. Likewise, therapists usually specialize in treating certain types of problems and patients. When they are asked to treat someone with a problem which falls outside their area of expertise, they usually refer that person to another mental health provider. Also, they generally refer those individuals who have problems which produce counter-transference issues.

Within correctional facilities, these conditions for therapy are difficult to meet. Inmates who are referred to a mental health counselor do not have the luxury of seeking out a therapist whom they can trust and respect. In fact, inmates tend to equate mental health personnel with the administrative and security staff. Consequently, feelings of trust and respect are considered maladaptive. It should be noted that most inmates have always had a problem with such feelings because of their traumatic developmental histories, which generally result in severe character flaws/personality disorders. Therefore, prison merely heightens their pre-existing lack of trust and respect for authority figures. Likewise, mental health counselors struggle with their own feelings of trust/distrust and respect/disrespect toward inmates. When mental health counselors show compassion, sympathy, and/or empathy toward inmates, they are often perceived as "naive" and "idealistic" by both staff and inmates. Many times the inmates treat them with suspicion and contempt as they try to manipulate these counselors. Eventually, many of those mental health counselors become cynical, interpreting the inmate's mental health

complaints as manipulative ploys and/or as mere "whining." Those mental health counselors who continue to be compassionate and empathic are labeled "bleeding heart liberals" by many staff members. Conversely, the "idealists" call those mental health counselors who exhibit cynicism and contempt "hard-nosed conservatives" who are fatalistic. The "idealists" tend to perceive the "fatalist's" interventions as punitive while the "fatalists" say the "idealist's" interventions exemplify negligence. For example, in its extreme form a "fatalist" will place inmates in strip cells and restraints for eluding to suicidal thoughts while an "idealist" will only place them in strip cells and restraints after they have made a suicidal gesture/attempt. "Idealists" claim that the "fatalists" ignore Axis I psychopathology while emphasizing Axis II personality disorders. Conversely, the "fatalists" claim that the "idealists" ignore Axis II personality disorders while emphasizing Axis I psychopathology. Needless to say, within a correctional setting the largest hurdle for mental health counselors to overcome is their tendency to overemphasize either Axis I or Axis II pathology. The former perpetuates distrust among the inmates while the latter perpetuates staff exploitation. Mental health treatment programs have a tendency to become a facade, beneath which both inmates and staff share feelings of distrust and disrespect. In such cases, mental health treatment programs are doomed to fail because: 1.) SOP is implemented rather than a treatment program, and, 2.) mental health counselors often undercut each other's interventions rather than complimenting or supporting them.

If mental health counselors don't get over this initial hurdle, there is little hope that their treatment will be successful because they won't even address the other hurdles which need to be jumped by the mental health team. Some of these other hurdles are briefly discussed below.

- 1.) Most inmates perceive their incarceration as punitive rather than rehabilitative or therapeutic. By definition, they find themselves in a "me" versus "them" situation. The "them" consists of all the correctional staff including mental health personnel. Therefore, what may appear to be a positive therapeutic relation may actually be a facade covering the inmate's distrust of and contempt for the mental health counselor.
- 2.) The limits of confidentiality are much broader in corrections than in free society. For example, if an inmate reports that he is concealing a "shank" or marijuana, the mental health counselor is obligated to break confidentiality and report it to security despite his denial of

suicidal and homicidal ideation. After security has been notified, they will confiscate the weapon or marijuana and present his case to the Office of Inmate Discipline.

- 3.) Those inmates who are classified with a maximum or high maximum security level are usually interviewed by their mental health counselor through the bars or tray-slot in their cell door, or in an office where they're cuffed and surrounded by five correctional officers. Needless to say, the surroundings are not conducive for therapy or evaluation.
- 4.) Mental health care is free of charge, which often results in a devaluation of the services by both the mental health provider and the inmate/patient who feels entitled to the mental health services on demand.
- 5.) Many of the inmates are on the mental health caseload because they are extremely difficult to manage in general population. Many of them don't have an Axis I diagnosis. They only meet the criteria for a severe personality disorder whose behavior is unpredictable, manipulative, self-indulgent, and assaultive. Therefore, both security and administration request mental health placement and intervention. Many of these inmates resent being on the mental health caseload and refuse to work with their mental health counselor, saying they do not have a "problem."

THE SOLUTION

How do we prevent the mental health staff from being polarized by the institution and by inmates with severe personality disorders? Unfortunately, there is no easy solution. The cards are clearly stacked against the construction of a cohesive mental health team. In fact, it is surprising that mental health teams work together as well as they do, given the nature of their clientele. Most psychiatric units complain of staff splitting when they have one or two patients diagnosed with a severe personality disorder. Corrections have mental health caseloads which are filled with these patients whose boundaries are blurred and whose sense of self is fragmented and situational.

In order for anyone to work with these individuals, they must have clear boundaries, knowing their limits and areas of responsibility and authority. Obviously, the more fragmented and ill-defined the mental health counselor's sense of self, the less effective he/she will be as a clinician. These mental health counselors tend to defend their poor clinical judgement by either adopting an

"idealist" perspective and blaming the "fatalists" or vice-versa. In such situations, patient staffing becomes a battleground on which the "idealists" and "fatalists" fight over diagnoses and intervention while sacrificing the inmate. The weapons of battle consist of mental health jargon, political loyalties within the institution, and concerns over liability.

To avoid staff polarization, supervision of the whole mental health team appears to be mandatory. Often the mental health team will mirror the inmate's self-defeating behaviors and relationships in what's called "parallel process." Generally, people who are involved in this process are unable to recognize it without supervision. Many times, such supervision falls into a gray area where supervision and therapy overlap. This process might be painful and threatening to many mental health counselors because they have to look into themselves; but, this is the nature of the beast. Whenever therapists treat patients with primitive personality disorders, they invariably learn a lot about themselves, both good and bad. It is the supervisor's job to help each counselor deal with such issues, to diffuse the intense feelings caused by polarization, and to help construct a cohesive mental health treatment team.

RELAPSE TREATMENT UNIT

BY

NAN COTHRAN

CORRECTIONAL RELEASE CENTER

NEWTON, IOWA

RELAPSE TREATMENT UNIT

BOX 218

NEWTON, IOWA 50208

PRESENTED BY: NAN COTHRAN

In an effort to provide meaningful treatment for parolees and work releasees who violate conditions of their release with substance abuse the Iowa Department of Corrections, through enactment of H.F.780, developed the Relapse Treatment Unit. The Relapse Treatment Unit (RTU) is an Iowa Division of substance Abuse licensed in-patient treatment program located on the grounds of a minimum security correctional facility in rural Jasper County. The RTU building was originally a barn that was used as the first bunkhouse of the correctional facility in the mid-1960's. Through extensive renovation by inmate labor it was recreated into a living unit in the loft and a reception center, classrooms and staff offices on the ground level. The unit employs a director, three certified Substance Abuse counselors, five correctional officers and is often aided by student interns from several colleges and universities.

The correctional facility provides the unit with Management, clerical support, medical services, out-door recreation facilities and meals. It also provides a close security environment by performing random drug screens and

has the administrative responsibility of ensuring that program expectations are meeting all licensing standards and American Corrections Association Accreditation standards.

Parole officers and work release staff refer clients to the program director. If accepted, a hearing is held and as a condition of their status the client is placed at the Iowa Medical and Classification Center at Oakdale for several days for health screening and detoxification if necessary, and then transferred to RTU. Treatment at RTU is intense with clients involved in 10-13 hours of daily treatment activities for 45 days. A typical day starts at 5:30 a.m. with wake up, showers, unit cleanup and breakfast. This is followed by morning meditation which uses A.A and N.A. Thought for the Day, and a community group which addresses unit problems.

The first therapy group is one and a half hours in duration and could cover feelings, self-acceptance or grief issues. Each group lasts for seven days per topic. Other morning groups consist of denial, relationship issues, cultural differences, and recreation. During the afternoon we offer groups on Relapse, Power and Control, and Breaking Barriers. Each group has assignments which are discussed in the groups as well as with clients individual counselors.

Evening hours are used for Spirituality groups, A.A./N.A. meetings, and family groups. All visitation is scheduled around family groups, which are set up twice

during the week and also on Saturday and Sunday. For clients to obtain a visit, the family members must attend a one and one half hour education group. Our family groups address issues of ACOA, Inner Child, Co-Dependency and other relevant issues through the use of films and lectures.

Our program is very confrontive and each client is only guaranteed the first seven days of treatment. If they are not actively involved in treatment within this time, they are staffed and removed from the program. If removed from the program, they are automatically revoked and sent back to prison.

After completion of the RTU program, each client is set up for involvement with TASC workers in their home community. Again if they fail to follow through they are revoked and will not be offered any additional treatment on their current sentence.

RTU has provided Iowa with an effective alternative to revocation that directly addresses the issues that interfere with the success of many community based clients.

BREAKING BARRIERS

Gordon Graham and Co.
200 West Mercer, Suite 515
Seattle, WA 98119
(206) 286-3530

My Contract With Myself

I, _____ commit to
identifying three things that I've gotten used to that are barriers to
my personal growth and change.

1.

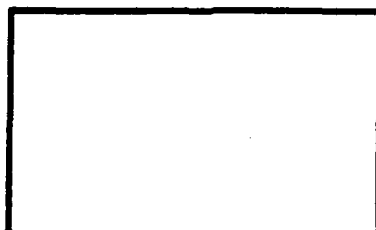
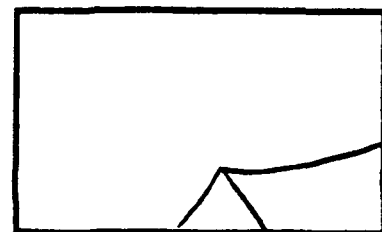
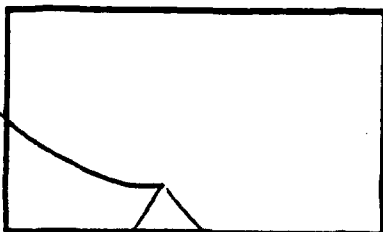
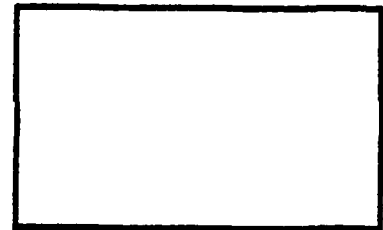
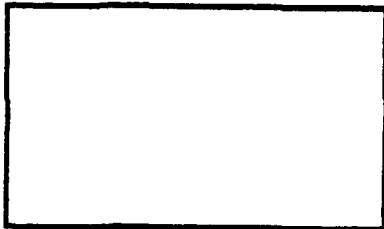
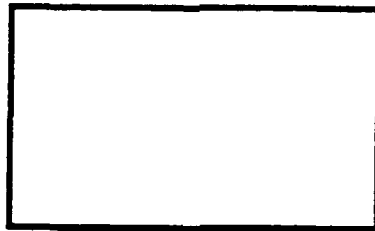
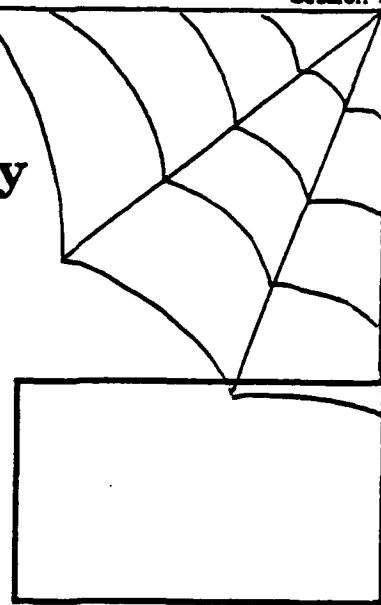
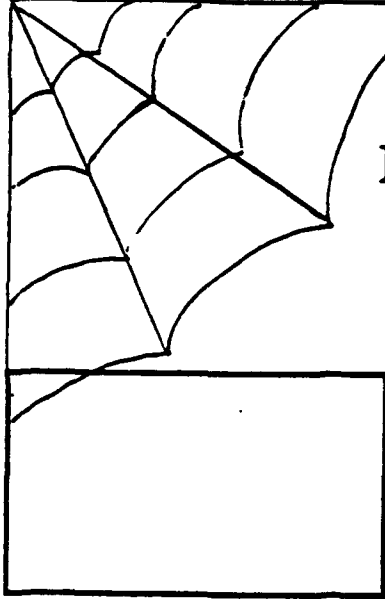
2.

3.

Signed: _____

Date: _____

Challenge Web My Current Reality



INCREMENTAL CHANGE

INCREMENTAL CHANGE, or "getting used to it" is a powerful process in our lives. What we have gotten used to in the past can determine how we live our lives in the future. Most of us get used to things "by accident," not because they are what we want in our lives. To control our lives, we must control what we get used to.

Example: When you first enter a prison setting, the noise is almost unbearable. It is hard to sleep. You are up-tight, out of place. Then gradually the noise ceases to exist for you. You no longer hear the doors slam. Prison becomes what we get used to...becomes "normal."

Example: If you have been in a relationship that is full of tension and hostility, and things run smoothly for a few weeks, you begin to wonder what's wrong...things are going too good. We can get used to unhappy relationships.

What have I gotten used to that stands between where I am and where I want to be?

SCOTOMAS

"WHAT YOU SEE IS WHAT YOU GET!!"

A scotoma is a term used to describe the blind spots that all of us have. Scotomas are created by prior conditioning and can blind us to seeing the many options that surround us. (Remember the "F" card). Because of the way we have been conditioned in the past, there are many opportunities and possibilities we simply can't see, so they do not exist for us.

Example: A person who has a long history of being in prison may look at 200 want ads and not see one opportunity. Because of the way we have been conditioned, the chance of employment is seen as slim to none.

Example: A person who has a record may need a loan to buy a car or to buy tools. He or she may not see a bank as an option for the loan, because due to prior conditioning, we "KNOW" people with records can't get a bank loan.

RETICULAR ACTIVATING SYSTEM

As human beings we are physically limited in our awareness of our environment. For instance, dogs hear sounds and smell odors that people do not. But we are also limited in the things we see, hear, feel, etc., in another way. Each of us has a RETICULAR ACTIVATING SYSTEM (RAS). This is a net-like group of cells in the brain. It is a natural filtering device which allows only those things we see as of PAY VALUE or a THREAT to get through our awareness.

Example: If you are standing in the breezeway talking to several inmates and other inmates are going by constantly, you aren't really aware of them. But the minute a guard walks by, he or she can be perceived as a threat and you instantly become aware and stop your conversation.

Example: If it is visiting day and you are expecting a visitor, there may be lots of noise all around that you don't even hear. However, the minute your name comes over the speaker, it gets right through to you as of pay value.

Example: If you are on parole and want to get a substance abuse problem under control, all information you hear about available programs will come screaming through as of pay value to you.

CAUTION

WE MAY NOT REALLY BE AWARE OF WHAT WE HAVE BEEN CONDITIONED TO SEE AS A THREAT OR AS A PAY VALUE. A VERY IMPORTANT STEP IN PERSONAL GROWTH IS TO DETERMINE WHAT IS OF REAL VALUE.

What's of value to me? Family? Freedom?

What am I looking for in my life? Security? Love?

Are the things that are of value to me now consistent with the life style that I want in the future?

Do I use threats to get through to other people? Is this behavior of threatening others getting me where I want to be? (Gordy uses the example of going to the hole because someone "made" him carry through on a threat.)

FINISHED FILES ARE THE RE-
SULT OF YEARS OF SCIENTIF-
IC STUDY COMBINED WITH THE
EXPERIENCE OF MANY YEARS
OF EXPERTS.

"It's so easy to stop learning, to live off the capital of what we once learned. No matter how educated we are, no matter how advantaged we are, everyone of us lives his or her life in one little wedge out of the total circle of what it means to be human. And unless we can borrow and lend experience through the medium of exchanging ideas, memories, carings, we are fated to stay imprisoned in the wedge."

Bonaro Overstreet

**Criminal Personality and Substance Abuse:
Interactional Issues for Intervention Programs**

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**A Paper presented at the Midwestern Mental Health in Corrections Symposium
May 28, 1992**

Criminal Personality and Substance Abuse: Interactional Issues for Intervention Programs

Introduction

A large percentage of individuals currently involved with the criminal justice system have substance abuse problems in addition to their patterns of criminal behavior. This conclusion is evident in the 1992 National Drug Control Strategy which states "... as many as 75 percent of those arrested for serious crimes test positive for drug use at the time of arrest. More than 50 percent of Federal prison inmates and 80 percent of State prison inmates report that they used drugs before incarceration" (p. 70). Treatment programs designed to address criminal behavior or substance abuse are currently available in many correctional facilities. While treatment of each of these problems separately is important, the interaction between criminal behavior and substance abuse should not be ignored.

The most basic assumption in this presentation is that the characterological composition of individuals involved in the criminal justice system can be divided into a series of cognitive correlates to maladaptive behavior. This is consistent with treatment theoreticians in both criminal personality (e.g., Yochelson & Samenow, 1976; Walters, 1990) and substance abuse (e.g., Annis & Davis, 1989; Donovan & Marlatt, 1988; Marlatt & Gordon, 1985). In these contemporary approaches the cognitive antecedents to the behavior are identified, with interventions developed at both the cognitive and behavioral levels.

It is proposed that there are similarities and interactions between the antecedents for

criminal behavior and substance abuse. In essence this produces an effect that serves to multiply relapse potential, as thoughts or behavior associated with one behavior pattern can then lead to relapse in the other. Similarly, identification of the antecedents associated with one behavior does not guarantee their identification with the other. Thus, unexamined links between the behaviors themselves may serve as an additional set of antecedents.

Using this premise, intervention programs designed for either substance abuse or criminal behavior can effectively heighten participant's self-awareness through an analysis of the similarities between these cognitive and behavioral antecedents. This may also provide additional incentive toward self-change, especially when similar intervention techniques are employed for both behaviors. Illumination of the similarities between these two behavior patterns can serve as a model for the exploration of other relevant lifestyle issues, and their interactions. Participants can be encouraged to apply self-change techniques to these troublesome behaviors as well.

Both etiological and psychological issues are relevant to an exploration of the similarities between maladaptive behavior patterns. This allows adequate understanding of the complex interrelationships inherent within overlapping problems areas, and can serve as a basis to enhance program efficiency and effectiveness. This is accomplished through a more thorough appraisal of the participant's lifestyle and the thoughts beliefs and attitudes that have led to trouble in their lives. This is followed with cognitive-behavioral intervention techniques, such as relapse prevention, which focus on the development of more adaptive cognitions and behaviors.

Etiological Issues

Individuals who fit a diagnostic pattern of criminal personality plus substance abuse can be divided into two major classifications: The substance abuser who resorts to criminal activity as a means of obtaining their substance (refer to case example # 1); or the traditional anti-social or narcissistic personality disorder in which drug/alcohol abuse is often a feature of the characterological defect (refer to case example # 2). In either case, the dual problem of drug use and criminal activity exist.

Assessment of the development of the dual problems can be helpful, as it establishes which of these patterns provides the best fit for the individual in treatment. In addition, their own perceptions of how the problems developed are a logical starting place. For instance, if an individual is a chronic drug abuser and resorts to criminal activity to support their addiction, they may wish to focus on their substance abuse issues.

Besides providing information on the participants perception of their problem, it also serves as a window to the path of least resistance. After the relationship has been established and the individual is used to self-exploration, the similarities and interactions can be explored. If one only area serves as the focus of intervention, the participant may never confront the assumption that controlling one behavior will result in control of the other. Thus, people who have resorted to criminal activity to support their substance abuse may assume that control over their addiction will result in remission of criminal behavior. Case # 1 provides an example of this confound. Alternately, people that focus on changing the elements of their criminal lifestyle will not necessarily identify substance abuse as a major factor in that lifestyle, and may assume this is not a problem. Case # 2 illustrates this event.

Psychological Issues

Similarities between substance abuse and criminal behavior are reflected in several psychological dimensions. Several personality characteristics of substance abusers and criminals are related. In this respect, both are viewed as impulsive, self-centered, and high in their need for stimulation. These characteristics are also representative of the cognitive and emotional similarities between the behaviors. They provide a framework by which an intervention specialist can bridge the gap between substance abuse and criminality.

It should be noted here that the goal of intervention is to decrease the risk of future criminal behavior or substance abuse, as both have a negative impact on both the individual and other members of society. Therefore, intervention is focussed in two directions. First, the ability to predict a relapse into the maladaptive behavior; and second, methods to prevent the predicted relapse from occurring. This is based on the principles of Relapse Prevention (Marlatt & Gordon, 1985), which are similarly applied to both substance abuse relapse, and a relapse into criminal activity. This gives the participant an intervention model with enough flexibility and direction to apply to multiple problematic behaviors.

Some of the common psychological similarities between substance abuse and criminal behavior are provided on the next page. While participants frequently endorse the characterological aspects, these are usually too broad, abstract and amorphous to lead to a meaningful change. They are however, helpful in drawing an individual toward more meaningful exploration of the specific behaviors, cognitions and emotions that are related to the characteristic. These can later be used to illustrate the similarities and interactions between the psychological events related to substance abuse and criminal behavior.

The Psychological Similarities between Criminal Behavior and Substance Abuse

Characterological

IMPULSIVITY

NARCISSISM OR SELF-CENTEREDNESS

HIGH NEEDS FOR EXCITEMENT and/or ACTIVITY

Cognitive

CORROSION/CUTOFF

CLOSED-CHANNEL THINKING

VICTIM STANCE

SHOULD

GENERALIZING TO THE ABSURD

CAN'T

HAVE TO

BLAMING

DISTORTION

RIGHTEOUS INDIGNATION

GLORIFICATION

ALL OR NOTHING

Emotional

SELF-PITY

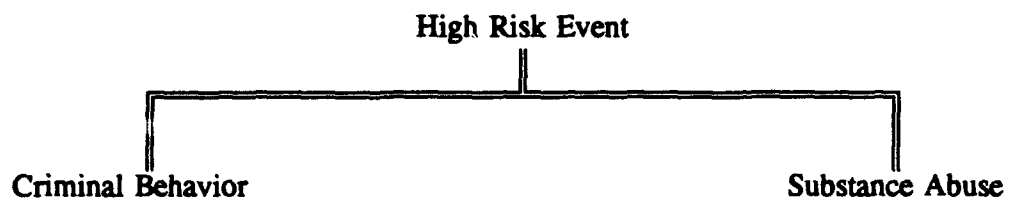
ANGER

GUILT/SHAME

BOREDOM

Models of the Interactive Relapse Process

Dual Relapse Potential



Relapse Contamination

High Risk Event ===== > Substance Abuse ===== > Criminal Activity

or

High Risk Event ===== > Criminal Activity ===== > Substance Abuse

Intervention using Relapse Prevention principles

Identification of the psychological events associated with criminal activity or substance abuse allows a person to lay the groundwork for preventing relapse into that behavior. Since this is intended to be used within existing programs, it is assumed that the etiological and psychological factors have already been identified and processed for either criminal behavior or substance abuse.

This intervention model uses five stages. There are specific goals within each stage, with the general goal of self-exploration and self-change underlying each stage. The five stages are: 1) Relapse Process Comparison; 2) Relapse Signs Identification; 3) Search for Dual Relapse Events and Contamination; 4) Relapse Prevention Planning; and 5) Practice.

Relapse Process Comparison

The first step introduces the similarities between the cognitive processes underlying relapse into either activity. Specifically, the inhibitions developed over a substantial period of treatment and abstinence (going straight) gradually break down through unchallenged lapse into the patterns of behavior, thought, and feeling associated with the pre-treatment state.

Relapse Signs Identification

The second step consists of identifying the cognitive, emotive and behavioral aspects of the initial return to the maladaptive behavior. These represent the high risk events for relapse. High risk events are listed for both criminal behavior and substance abuse.

Search for Dual Relapse Events and Contamination

Both sets of high risk events are compared in the third step. Preliminary comparisons are made and dual relapse events are identified. This is followed by the search for contaminants that could trigger relapse into the other behavior. In this manner, both models are used to illustrate the interactions between substance abuse and criminal behavior patterns

Relapse Prevention Planning

Fourth, plans are developed to effectively deal with each of the high risk events identified. Participants are encouraged to develop plans to deal with the specific high risk events. In addition, "inoculation" plans are discussed and implemented. These include activities that are proactive, and inconsistent with the criminal or drug cultures. These would include such things as wellness and holistic health components, association with support groups, and religious or spiritual activities.

Practice

Finally, role plays or other methods of practice are used to evaluate the effectiveness of the personal intervention plans. Participants are encouraged to evaluate their own effectiveness in dealing with high risk events. In addition, feedback from other group members who have "been there" can be an invaluable asset.

CASE EXAMPLE 1

A former client decided to avoid all people who were associated with drug use as part of his substance abuse relapse prevention plan, since he felt compelled to use when he was in their presence. He did not consider himself a criminal, but had resorted to robbery in the past in order to obtain drugs. This past association led him to an "opportunity" to drive a getaway car in a hold-up, which eventually led to his granting a "favor" to a criminal associate by holding some cocaine for him. Consequently, this led to his use of the cocaine to coerce a sexual relationship with a woman. Shortly thereafter he relapsed as a result of this relationship. The roadmap he followed when recounting the events leading to his relapse provided the key to the thought processes that were involved. Initially he identified his association with the woman as his "only" error. Through a more thorough analysis of his thought processes, he eventually filled in additional pieces, and even admitted that the "excitement" he experienced while planning the first criminal event, was a preliminary step toward the substance abuse relapse.

CASE EXAMPLE 2

An individual had been associated with criminal activity since an early age and had spent over half of his life in prison. He finally decided to "go straight" which entailed getting a job, getting married, and settling into a "normal routine." Unfortunately, he found the lifestyle boring, and often found himself comparing his forty hour weeks with the quick heists that netted him greater cash rewards in his previous lifestyle. In the past he had celebrated after a "heist" by using drugs. It served both as a reward and calmed him down from the tension and excitement associated with criminal activity. The unexplored "reward" factor, coupled with the dissonance he felt in pursuing his new lifestyle led to a dual relapse. Essentially, he decided to reward himself for his hard work one payday by purchasing and using cocaine. While high on the drug he reevaluated his current lifestyle and determined that the normal routine was not for him. In addition, he decided to replace the money spent on cocaine by pulling a small robbery.

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**RELAPSE PREVENTION MODEL WITHIN MISSOURI
SUBSTANCE ABUSE PROGRAMS**

BY

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RELAPSE PREVENTION MODEL WITHIN MISSOURI SUBSTANCE ABUSE PROGRAMS

Introduction

This paper presents a description of Missouri's substance abuse treatment programs and demonstrates how relapse prevention strategies are applied in our treatment settings.

Statewide Corrections Strategy

In the past two years, Missouri has established several new drug treatment programs that total 600 beds, with 200 beds to be added soon. This dramatic increase has occurred in conjunction with Missouri's efforts to establish alternatives to traditional incarceration. The bulk of the beds are for parole violators or probationers sentenced under a 120-day sentencing law.

Two of our programs, the Farmington Treatment Center (two facilities) and the Mineral Area Treatment Center (Potosi) will be described below. These programs are twelve weeks in length and provide 400 treatment beds.

General Philosophy and Relapse Prevention

Missouri endorses a very structured treatment approach that is consistent across all programs. This approach is described generally as cognitive, confrontive, and reality based. Emphasis is placed upon group therapy, structured twelve-step study and drug education. Services are augmented by physical training, AA meetings, life skills and self-study groups. All staff, including psychologists, substance abuse counselors, caseworkers, corrections officers and probation and parole officers take an active role in the treatment process.

Early in our planning efforts, we determined that relapse prevention would play an integral role in our programming. In addition to the general benefits of relapse prevention, we chose to emphasize this approach for two reasons:

- 1) The vast majority of our clients have undergone drug treatment before and returned to drug usage; and
- 2) Our projected treatment staff to offender ratio (1:15) and the nature of our population demanded that we establish a well defined and structured treatment approach.

Specific Program Elements

The relapse prevention model underlies our entire treatment philosophy. Specific application of this approach occurs in two basic ways.

Educational Program

The basic concepts of relapse prevention are introduced through a weekly film series and a one week daily series of general educational lectures. In addition, a more in-depth understanding of relapse prevention is provided through a series of special lectures that occur twice per week (1 1/2 hours per session). This series provides information on post-acute withdrawal, the recovery process, symptoms of relapse and relapse prevention strategies. This foundational material serves as an introduction to the personalized relapse management module.

Personalized Relapse Management Module

During the last six weeks of the program each offender completes a self-directed module of relapse management based upon the material of Terence Gorski. Approximately one hour per day is required to complete assignments. Counseling staff monitor the offenders work at least weekly and provide feedback for further progress.

The module provides a series of assignments designed to help the resident understand the relapse dynamic, identify his relapse triggers and establish specific coping strategies. These assignments require the offender to continually monitor his symptoms and explore the personal and interpersonal factors that lead to relapse.

An important component of this process is the integration of the twelve step program into the relapse module. Offenders are guided in utilizing the twelve step program to cope with each of the trigger points and symptoms.

Initial Evaluation

Informal feedback from offenders indicates that the relapse prevention material is the most helpful component of the program. Initial follow-up data indicates that recidivism in program graduates is much less than that of offenders sentenced for the same period of time who do not go through the program, or offenders sentenced to typical incarceration. The Department is establishing a multifaceted research design that will evaluate the success of participants two to five years post-treatment.

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**The structure of emotion in psychopaths:
A motivational analysis of Sadistic aggression.**

Paper presented to the Mid-West Conference on Corrections and Mental Health. Kansas
City 27th-29th May 1992

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Abstract

The structure of emotion in psychopaths: A motivational analysis of Sadistic aggression.

This paper considers formulations of sadistic aggression and some case histories, from which common themes are drawn. The paper argues that there is a need to develop an integrated theory of sadistic aggression and classification of sadistic aggressors. It suggests that this may be done by focusing on the experience of motivation. Apter (1989) has proposed a theory of motivation which is described as both phenomenological and structural. The theory, known as the theory of psychological Reversals, is outlined and some similarities between Theodore Millon (1989) and Apter's notions are indicated. In sum, the theory hypothesizes several pairs of motivational states between which a person may move (reverse). Several cases, representing types of mentally abnormal offenders who have been detained indefinitely under United Kingdom mental health legislation as suffering from "psychopathic disorder", are used to describe and illustrate the variety of emotional structures and phenomenological experience among those who have committed acts of sadistic aggression. It is proposed that the theory may be developed to provide a motivational taxonomy of sadistic aggressors, a framework for clinical evaluation of risk and identifying therapeutic targets. How the theory has been employed in the reduction of sadistic fantasy will be described.

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**The structure of emotion in psychopaths:
A motivational analysis of Sadistic aggression.**

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1 INTRODUCTION

When I hear people say, "nothing works", in respect of the management of non-psychotic mentally abnormal offenders, I wonder what process of reasoning has lead them to make such a statement. It is an odd conclusion for applied professional scientists to make, whatever their discipline. Faced with any problem scientists would start with a description of the known data, classifying that data, formulate explanatory models of the relationships between major components of the data and then explore the robustness of the explanatory models which have been constructed. The concepts of theory and science are part of all our training and yet we are reluctant to engage in the rigour of that process when faced with the sadistic aggressor. It is my view that there is too much politics and pragmatism and insufficient theory, in the decisions about managing personality disordered offenders, the so-called psychopath.

In this paper I want to introduce a theory of human motivation and emotion into a discussion of sadistic aggression. The theory is known as Reversal theory. I do not want to imply that this is the only theory applicable to the problem but it is a "big theory", concerned with personality, emotion and motivation among the general population. It happens that it is sufficiently robust to be applied to extremes of human experience.

It has many similarities with Millon's (Millon 1982, 1989) work, although Reversal theory has developed quite independently of Millon's. It has been applied to an enormous range of issues including, counselling, advertising, safe sex programmes, smoking cessation, sport, physiology, stress, education and delinquency to name but a few. I am not going to be able to provide anything but a brief introduction to this theory in the time available so I ask you to tolerate a degree of "unknowing".

My intention is to outline some common features of sadistic aggressors. Then I will construct the theory, layer by layer, and finally I will demonstrate how it might be applied to the problems of describing, understanding and planning the treatment of the so-called psychopath.

2 SADISTIC AGGRESSION AND AGGRESSORS

Brittain's (1970) account of the general profile of the sadistic murderer includes the following excerpts;

"...a day dreamer with a rich fantasy life...He would be vain and sensitive to threats to his self esteem....is drawn to Nazism because of their associations with concentration camp tortures and untrammelled power over other people....He kills in the course of sexual assaults....Sexual intercourse does not necessarily occur at these times, he may instead masturbate beside the victim. At these times he is in a frenzy of excitement."

The features which may be significant in this discussion include the suggestion of high levels of aversive arousal associated with vanity and personal threat, as a psychological backdrop to the offending. Secondly there is clearly a reference to mastery of the victim. Thirdly the experience of the killing is that of intense excitement. The focus of these factors is essentially phenomenological in as much as it is the experience of the individual which is significant in the description. MacCulloch et al (1982) attempted a behavioural formulation of sadistic aggression but in the end succumbed to the inevitable experiential definition. Their definition of sadism as,

"...the repeated practice of behaviour and fantasy which is characterised by a wish to control another person by domination, denigration or by inflicting pain for the purpose of producing mental pleasure and sexual arousal...."

is further evidence that in the end we must describe and define the problem in experiential or phenomenological terms. It follows that we are most likely to find an explanatory theory of sadistic aggression from the phenomenological, rather than behavioural or physiological domain. I will return to this in a moment.

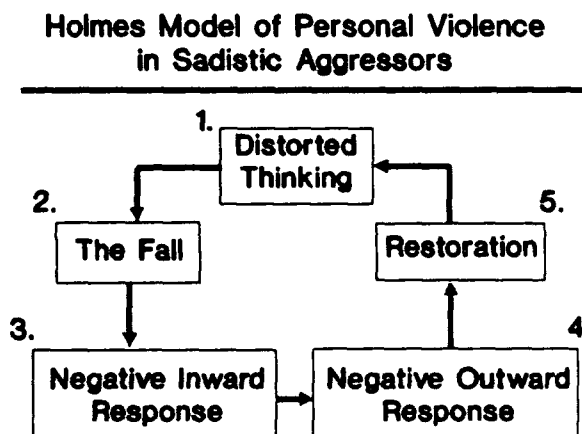
The pattern of generally high levels or high frequency of aversive arousal coupled with serious aggression experienced in a state of intense excitement is apparent in many case histories of serial murderers. West (1987) retells the story of a number of these people, revealing this pattern.

The "Son of Sam" murderer, David Berkowitz, was someone who felt rejected by women, fearful of his impotence being discovered, and six months after discovering the pathetic history of his natural parents, he attacked his first victim. He described the exhilaration of the hunt in the killing of his subsequent victims. He reported becoming sexually aroused while watching his victims, prior to shooting them. This excitement was enhanced by the taking of risks.

Peter Kurten, otherwise known as the "Monster of Dusseldorf" was eventually executed having raped and murdered or attempted to murder at least 40 women and girls. He was described as being vain and easily angered, to the extent that he once stabbed a man to death for having bumped into him in the street. His childhood was a nightmare of abuse and it is difficult to conceive of him as being anything other than a tense and volatile man. The act of choking and stabbing was often sufficient to precipitate orgasm, especially if the victim struggled. He was unable to have conventional sex without fantasizing about some violent act and he derived great pleasure from telling his captors of his various exploits.

These two examples are interesting because they share several important features. Like so many serial murderers Berkowitz was able to sustain an acceptable social persona despite his violent activities. Kurten was probably less able to do this but must have had some capacity to change significantly to have avoided capture for so long. This suggests that at least some serial murderers are capable of a clear change in behaviour, emotion and cognition which facilitates reasonable adjustment to social circumstances prior to and soon after killing someone. In 1989 I tried to explain this phenomenon by bringing together aspects of cognitive psychology and reversal theory. Secondly, it is apparent that the act of violence serves a particular psychological function, compensating for the experience of humiliation, or transgression.

These case history's are very consistent with the model of personal violence among serial killers offered by Holmes (1990). He proposed a five stage, circular model starting with Distorted thinking. At this stage the killer is described as being, "in a positive psychological equilibrium state. He is not in a position to ponder the repercussions of deviancy because he has either blotted out the consequences or he is at the time more interested in the intrinsic or extrinsic rewards of his behaviour."



From Holmes (1990)

The second stage is The Fall, in which a single or accumulation of real or imagined stimuli precipitates a dramatic personal reaction. "He will store these incidents deeply within his psyche because his ego is so large. The violent reaction which must follow, is disproportion to the event." This reaction may take the form of symbolic aggression in which deviant fantasy is employed during masturbation. With some of the people I have worked with, I have noted a very clear relationship between both the frequency and deviancy of masturbatory imagery, and social tensions. As people become more socially competent the frequency and deviancy of masturbatory fantasy reduces, although this is not always the case.

The third phase is that of Negative Inward Response in which the killer mentally confronts the source of his feelings of inadequacy. They may do this by self talk in which they re-establish their own status and denigrate the position of others, in statements such as, "Who does that bitch think she is dealing with." It is also during this stage that the means by which this self validation may be established is considered. This is the lead into the fourth stage of Negative Outward Response in which his self-affirmation is pursued. Holmes comments, "Once he commences to validate and affirm his personal superiority, he is not in command (it becomes a compulsive need) and chooses vulnerable victims Because he cannot risk a further negative reality message."

Only following this stage, now in the stage of Restoration, does he become aware of the risks and consequences. He seeks to dispose of the evidence and make his escape. He has then met the psychic demands of restoring his primacy and has returned to the pattern of Distorted Thinking in which he functions acceptably in society.

Isen (1984) has postulated that the relationship between mood and memory might be understood in terms of a "Repair" and "Maintenance" model. With negative mood, people seem to have greater access to thoughts which will "repair" the mood. With positive moods, subjects will have greater access to thoughts which will "maintain" the positive state. Using this model in relation to violent sexual aggressors, it could be hypothesized that adverse social transactions, for instance being humiliated, will be "repaired" by the availability of compensating imagery, intent and behaviour involving dominance. There are a number of predictions which emerge from this proposition. For example, the greater the transgression to self esteem, the more dominant or deviant will be the compensatory imagery and behaviour. At Birmingham University we are just testing this hypothesis in relation to hostile fantasy among normal populations and the evidence to date is supportive of the "mood repair" function of hostile fantasy. Although Holmes does not make reference to social cognition theory, it seems that his model has some tenuous theoretical support.

3 REVERSAL THEORY

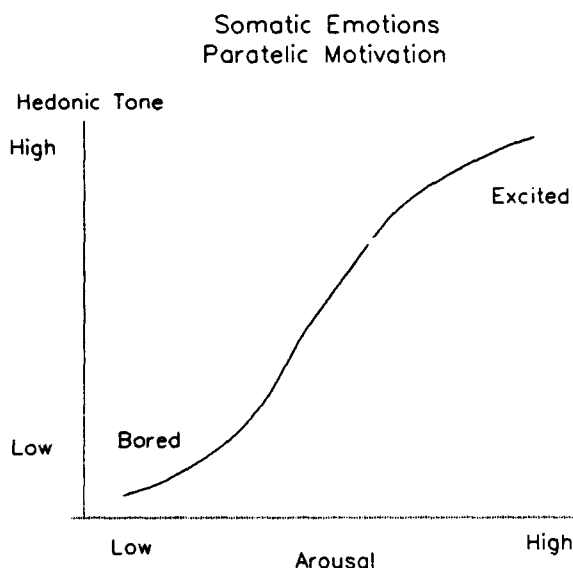
The question arises, what is the nature of this process where people move from one kind of experience to another. In the Holmes model, what is the psychology, the phenomenological process involved in movement from one stage to another? We may accept that the model is a parsimonious account of observations made about sadistic aggressors, but can we elevate it to the status of "theory".

Until recently there has not been a theory capable of providing the structure for systematically exploring the phenomenology of offending. Reversal Theory, developed by Micheal Apter, is described as "structural phenomenology", or more accurately as the "study of structure in the phenomenological field" (Apter 1989 p. 2).

The theory postulates that we can consider emotional experience in two realms. The somatic and transactional emotions. Somatic emotions are those which relate to how one experiences arousal. Transactional emotions arise out of our experience of interacting with others and the balance and imbalance of social exchange. Many of you will be familiar with social exchange theory or Transactional analysis which embody the basic notion of social transactions.

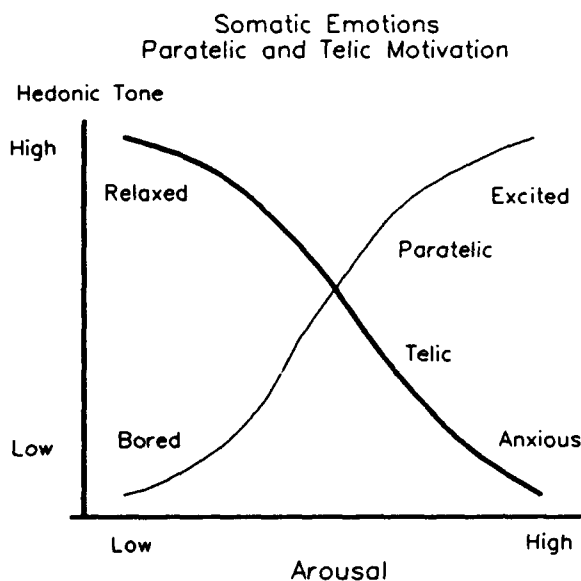
3.1 Somatic Emotions

If we look at somatic emotions first, there is a relationship between arousal and how we experience that arousal. Being highly aroused can feel good or bad. We can be motivated to increase or sustain high arousal or be motivated to reduce it as quickly as possible. In the first instance we can plot the hypothesized relationship between arousal and how good we feel, let's call it "hedonic tone", as in this illustration. At low levels of arousal there is low hedonic tone and we might describe this state as boredom. At high levels of arousal we have high hedonic tone which we can identify as excitement. Clearly in this relationship we would be motivated to increase our arousal because it is associated with increased hedonic tone. It is also probable that we would be orientated to immediate experience and sensation rather than important tasks or long term goals. We call this the Paratelic state.



But this is not the only relationship between arousal and hedonic tone. We all know that we can achieve high levels of hedonic tone at low levels of arousal, which we call "feeling relaxed". Equally we can feel terrible when highly aroused, like just before an exam when we feel anxious.

This second relationship we can superimpose on the first. In this second state we are motivated to reduce arousal because high arousal is associated with unpleasant experience. We are likely to be more serious in this state, be concerned about the consequences of our actions and address those goals which are of significance to us. This more serious minded state is called the Telic state. Here we have a pair of relationships between hedonic tone and arousal, each representing differing states of motivation.



The third, and most innovative element of the theory is the hypothesized relationship between this pair of motivational states. It is proposed that although an individual may be predominantly inclined to experience one or other of these states, people may move, or REVERSE, between the states at different levels of arousal, thereby dramatically changing their experience of the world and their intentions. For example, someone free

falling at 7,000 feet is likely to be in the paratelic state. The high levels of arousal will be associated with great pleasure. But something goes wrong when he reaches for his rip cord finds that it won't budge. It seems probable that his experience of the occasion will change dramatically. He will reverse into the telic motivational state in which high arousal is associated with low hedonic tone. It is an experience that we all have had at some time, while driving or in sport. It is strange to me that psychology, or any other discipline for that matter, has been unable to provide an adequate theoretical structure to account for that simple transition between excitement and fear at high levels of arousal, neither can we adequately describe the process by which we move from feeling relaxed, while lying on the beach, to feeling bored and desperate to do something more interesting.

The psychological backdrop of sadistic aggressors you will recall is commonly tension and turmoil, or high arousal in the telic state. In contrast, the experience of the offence itself as being "intense excitement", is very clearly paratelic. The suggestion is therefore that the offending behaviour is associated with a paratelic motivational state although there may be reason to suspect aversive telic experience in his day to day life.

3.2 Transactional Emotions

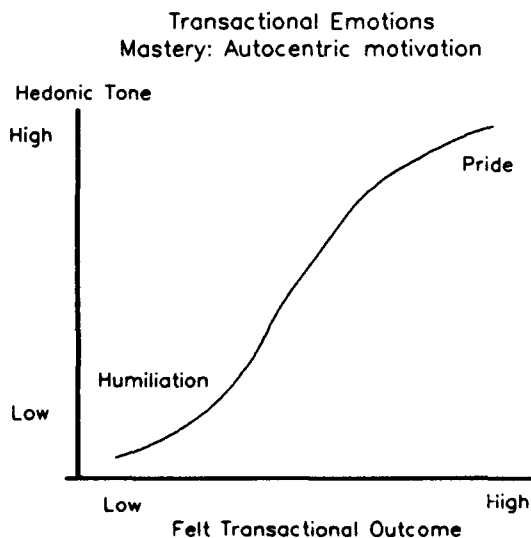
Having given you the basic ideas of pairs of motivational states and psychological reversals, I want now to look at how people experience personal relationships. Reversal theory offers several more pairs of motivational states which in combinations provides a general framework which is sufficiently flexible to consider anti-social personalities and sadistic aggression.

In this analysis we are still concerned with hedonic tone but instead of arousal we are interested in social exchange. The term "felt transactional outcome" (FTO), has been used to describe the phenomenological consequence of social exchange and it may be reported in terms of loss and gain. We can look at the experience of transactions from several points of view. First lets consider the experience of winning and loosing in social exchange.

3.2.1 Mastery: The experience of winning and loosing.

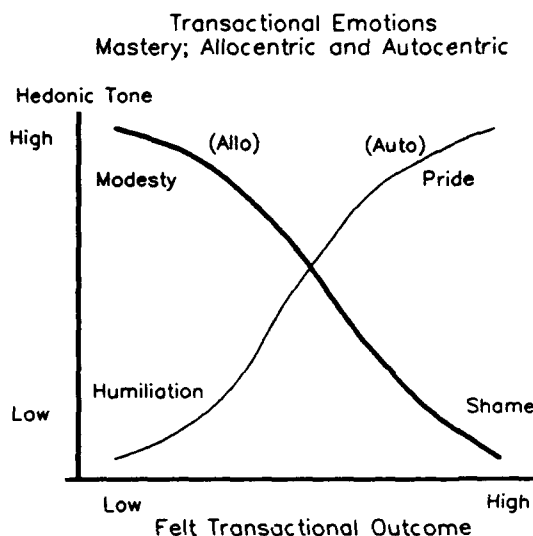
The obvious relationship between hedonic tone and FTO is indicated in this illustration in which net loss in FTO, arising for example, from being told off by your boss in front of colleagues, is associated with being humiliated; it does not feel pleasant; it has low hedonic tone. This experience contrasts with that of pride where high FTO, arising perhaps from winning an argument with an obstructive colleague, feels good; it has high hedonic tone.

In both of these situations we are orientated towards power, control and relative dominance, mastering or being mastered and how this affects us. Because it is concerned with how the transaction affects one-self it has been termed "autocentric".



But as with the previous pair of motivational states this is not the only relationship between FTO and how good we feel. Sometimes we can be concerned with how FTO affects others. This relationship between FTO and hedonic tone we describe as "allocentric" motivation. "Allo" taken from the Greek word for "other".

Take for example a situation where a friend, for whom you have always harboured a desire, comes to you, upset because of the demise of an important relationship. You share some wine and as the evening mellows you become increasingly intimate. The inevitable happens. In the autocentric mode you may experience pride for having finally attained your goal, confirming your own irresistible attraction. You then think about what has happened and realise that your friend was vulnerable and would only have allowed this to happen if they were in emotional turmoil. The transaction remains the same, but the experience of that transaction changes dramatically. You now feel shame, having reversed into the "allocentric" mode.

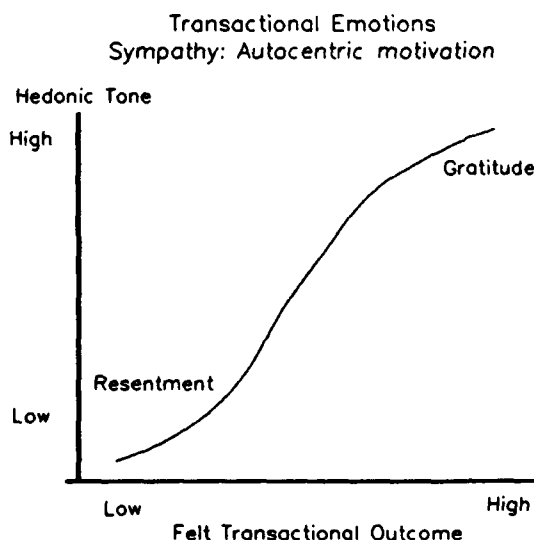


3.2.2 Sympathy: The experience of giving and being given.

Lets now look at the autocentric and allocentric motivational states in a new context of giving and being given.

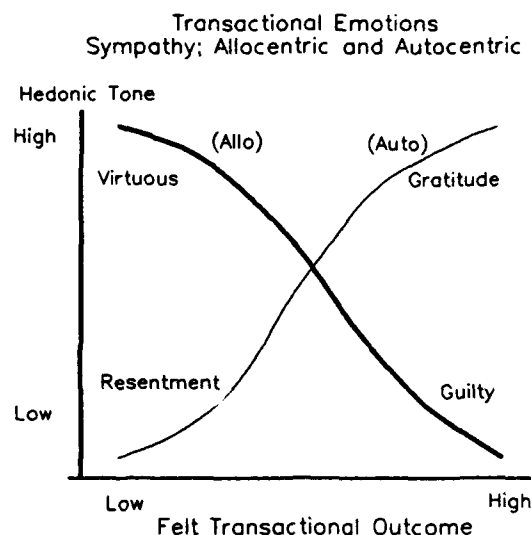
Again there is the obvious relationship whereby being in receipt of someone's generosity provides us with both high FTO and high hedonic tone. It makes us feel good and may be described as gratitude. With low FTO, such as when you enter into a social transaction with the mistaken expectation that your contribution will be reciprocated you feel resentful.

This is how it feels when we are orientated towards how the transaction affects us. However if we become concerned about how the transaction affects someone else, the experiences radically changes.



In the previous example, had you restrained your impulses and allowed your friend to take up your time, drink your wine, eat your food, bore you with their tale of woe, and then you tucked them into bed with some coa coa, you may have felt a degree of virtue.

In the same way, allowing a child to win in a game or letting a colleague have the last word in an argument may feel good, or virtuous, even though FTO is adverse. Failing to allow the child to win or the colleague to have the last word may cause us to feel guilty if we are concerned with the effect of this transaction on others; that is, if we are in the allocentric mode.



3.3 Review of Structure

At this stage it may be worth summarising the pairs of motivational states which have been discussed. To do this I will contrast them with Millon's fundamental bipolarities which he uses to produce his classification system of personality disorders which influenced DSMIII.

States and Dimensions of Personality Apter and Millon

Apter	Millon
Pairs of Motivational States	Bipolar Dimensions
* Paratelic - Telic	* Pleasure - Pain
* Autocentric - Allocentric	* Other - Self
* Mastery - Sympathy	* Active - Passive
* Negativism - Conformity	

Millon argues that these bipolarities can be used to divide people into broad classes of disposition. In the first instance he argues that people can be divided by the type reinforcement which they seek. There are those who generally seek the enhancement of pleasure, and those who prefer to minimise pain. You will recognize the similarity with the Paratelic - Telic states.

Secondly, there are those whose source of reinforcement is primarily other people, and those who are orientated towards themselves as a source of reinforcement. Again we can see a similarity with RT notions of Auto and Allocentric motivational states.

Finally Millon identifies the strategy with which people may seek that reinforcement as a further means of dividing the population. There are those who are Active in pursuit of their needs and others who adopt a Passive strategy. There is not a clear RT parallel to this but it does have echoes of the Mastery - Sympathy distinction. There is a fourth pair of motivational states in RT which I will not go into in this paper.

4 CLASSIFICATION

Millon's Classification of Personality Disorder

REINFORCEMENT		STRATEGY	
		ACTIVE	PASSIVE
SOURCE	Dependent	Histrionic	Dependent
	Independent	Anti-social	Narcissistic
	Ambivalent	Passive Aggressive	Compulsive
TYPE	Detached	Avoidant	Schizoid
	Discordant	Sadistic	Self Defeating

This illustration provides the matrix used in developing the classification of personality disorders. In the top right we see strategies of being Active or Passive. On the left we see the source and type of reinforcement divided by a kinds of abnormality described by Millon. It is worth noting that only the Ambivalent groups display "change" as a characteristic of their disorder.

Finally, the bottom line of this illustration includes the most recent extension of Millon's theory (Millon 1989) in which Sadistic and Self-defeating types emerge from the identification of discordant associations with reinforcement in some disorders. We can think of it in terms of pain and pleasure having a reversed significance in these people. Millon accepts that this is the least satisfactory of the influences on classification.

Ron Blackburn (1975, 1986) has published some work which divides mentally abnormal offenders into four groups of Primary and Secondary psychopaths, Inhibited and Over-controlled personality disordered clients. Later Blackburn (1989) considers the Millon categories which emerge in each of these groups.

Classification of Mentally Abnormal Offenders

Blackburn	Millon
Primary Psychopath	Anti-social Narcissistic Histrionic
Secondary Psychopath	Avoidant/Schizoid Dependent Passive-Aggressive
Inhibited	Avoidant/Schizoid Dependent
Overcontrolled	Dependent (? Compulsive)

The results are shown in this illustration. The Million types reasonably reflect the psychometric properties of Blackburn's types although it is a surprise to me that the Overcontrolled offenders do not display Compulsive characteristics. Perhaps they will when the numbers get larger.

5 REVERSAL THEORY AND PSYCHOPATHS

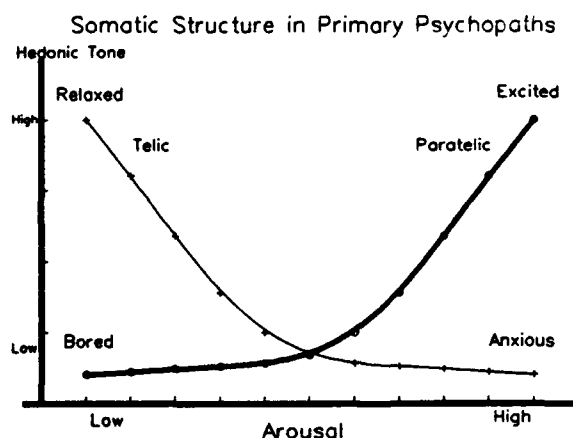
What I would like to do now is take two examples of Blackburn's types, the Primary psychopath and Overcontrolled offender and see how we understand them and their behaviour in RT terms. I have chosen these two types in order to bring out some of the features which an RT approach contributes to understanding psychopathology.

5.1 Primary Psychopaths

Blackburn identifies the primary psychopath as an extroverted, hostile, poorly socialized, aggressive and impulsive character. This is the archetypal psychopath which is commonly recognised and who it is argued is unable to establish significant personal relationships and who belligerently asserts their own primacy in any encounter. They have difficulty sticking at tasks, get bored easily, their sexual lives are impersonal, violence may appear gratuitous or out of proportion to any provocation. They do not see that they have any need to obey rules. They are also likely to be multiple aggressors. It is likely that the many sadistic aggressors would be classified as primary psychopaths.

Drawing these themes together, RT might speculate that the dominant motivational modes of the Primary psychopath are those of Autocentricity, Mastery and Telic motivational states. There is a relationship between these in that their own primacy (Autocentricity) is of high significance, a feature of Telic motivation, and the strategy employed is the domination or Mastery of others.

In this illustration I have translated this RT formulation into hypothetical Telic and Paratelic functions. The first thing to notice is the "bull horn" shape of these functions which themselves reveal a degree of abnormality.



The Paratelic function at low levels of arousal is rather inelastic indicating that large changes in arousal are associated with small changes in hedonic tone. When arousal is high the Paratelic function becomes elastic, indicating that only small changes in arousal are required to make larger changes in hedonic tone. This simply reflects the common observation of these people that they seem to require intense levels of stimulation and have to expose themselves to danger, risk or do themselves or others significant harm in order to feel good. In RT terms, they suffer from intense boredom and have to get a long way up the paratelic curve in order to feel the benefit.

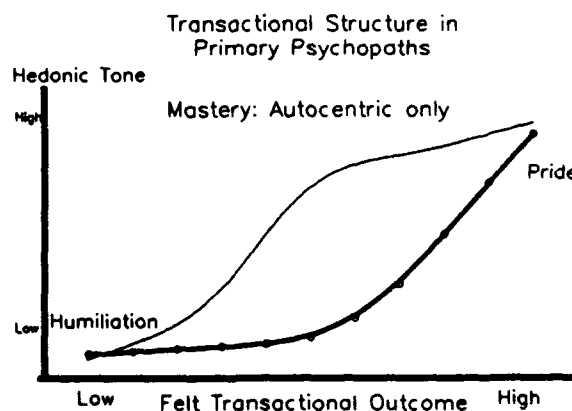
There are many examples of this in the offending behaviour of sadistic aggressors, but one dramatic example of this need emerged in the case of a young male sadistic aggressor who was incarcerated in a psychiatric medium secure unit. He contrived to get put into seclusion by smashing some furniture. What the staff failed to realise that he had torn up a coke can and inserted in his rectum. Once in seclusion, he removed it and began cutting himself inflicting deep wounds in both arms requiring almost a hundred sutures. He reported feeling no pain but a combination of "exhilaration and relief". He especially enjoyed the high speed ambulance ride to the emergency department and the ensuing attention and excitement.

The Telic function is postulated to be a mirror image of this. At low levels of arousal the function is elastic so that relatively small increases in arousal precipitate substantial reductions in hedonic tone. This reflects the common observation of anti-social aggressors that their irritable, angry or frustrated responses appear to be out of proportion to the size of the problem. However their response is in proportion to the fall in hedonic tone. In other words it is the shape of this function which is abnormal, again reflecting the distorted significance of events and vulnerability to frustration and provocation among this population.

We can also see the implication of a reversal from a Telic to Paratelic state at a low level of arousal. The combined features of dramatic fall in hedonic tone and the intensity of arousal required to recover this helps us understand the wild variation of mood and conduct in these people.

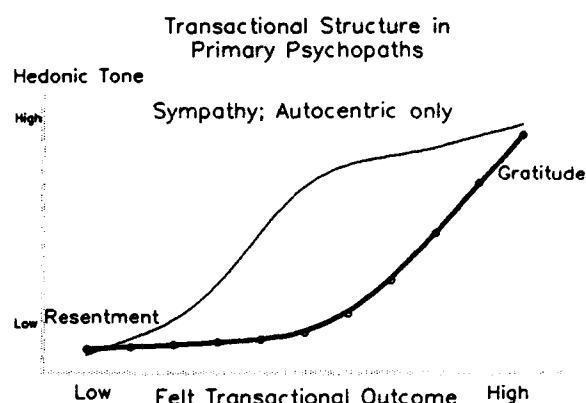
So far then, the Primary psychopath has an abnormality of construction, or elasticity, in the structure of somatic emotions. The result is that they are quick to experience negative emotion and slow to experience positive emotion. The extremity of their responses to minor provocation and intensity of stimulation sought reflect this.

Transactional emotional structures among this group also have an unusual shape. This illustration shows a thick line representing the elasticity of the relationship between Felt Transactional Outcome and hedonic tone when combined with Autocentric / Mastery motivational states. It postulates that transactional outcome has to be very favourable indeed before the benefit is felt. Pride is something which arises only when near total domination is achieved. Equally, Humiliation is readily experienced with only slightly reduced Felt Transactional Outcome.



An illustration of this is a case in which a man left a pub having approached a woman who he had known. She had pretended not to know him and he was embarrassed and angry. He passed by another female and he interpreted her unwillingness to look at him as a personal insult. He perpetrated a prolonged and ferocious sexual assault on her leaving her close to death. He later told me that she had deserved it for insulting him. At that moment it was like making up for every bad thing that had ever happened to him. He was like a god and could do what ever he wanted. The light weight line represents a conceptual therapeutic objective in people who need so much to feel of value and so little to be humiliated.

We can also look at the same relationship in the context of giving and being given. FTO needs to be very favourable in order to have a positive outcome. The common experience is that of resentment despite significant variation of FTO. Again this is a frequent observation of psychopaths. They are extremely difficult to please and they appreciate what you do for them only briefly. If a high level of support is breached they quickly experience resentment and a sense of betrayal. They are frequently in a state of feeling that they have not been given enough.



In both mastery and sympathy modes there is an absence or at least a diminished capacity to experience allocentric motivation. As a result emotions such as modesty, shame and virtue or guilt are unusual.

In summary, the Primary psychopath has an abnormality of construction, or elasticity, in the structure of both somatic and transactional emotions. In addition they have a diminished or absent capacity to experience allocentric motivation.

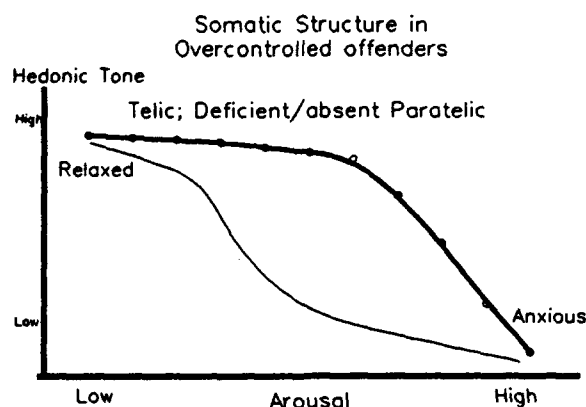
5.2 Overcontrolled

The overcontrolled offender contrasts with the primary psychopath. Blackburn describes them as being socially outgoing, conforming individuals, who are inclined to deny problems or psychopathology. These people are much more likely to be "one-off offenders" in the sense that they have only one offence. They are more likely to have killed their victim and their victim is more likely to be related to them, either as spouse or parent (Howells 1983). They tend to have a very positive view of their victim, both before and after the assault and often have depreciating attitudes about themselves. In Millon's categories this group may be identified as Dependent.

There have been several efforts to explain this kind of offence. One of the most interesting is that their denial of distress and psychopathology leads them to expose themselves to extreme levels of stress, so that when they do react, it has an explosive quality.

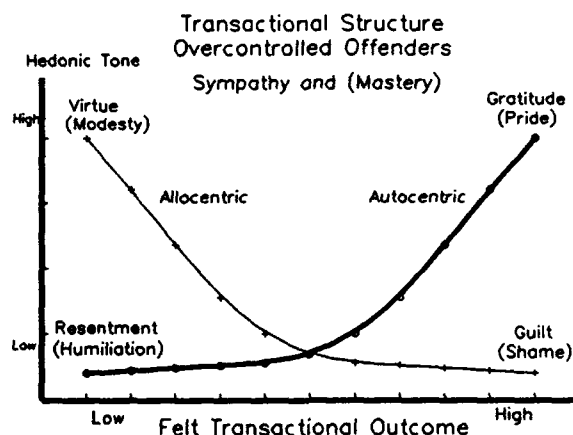
In RT terms dominant modes would therefore include Allocentric, Sympathy and Telic states. As with primary psychopaths these are somewhat interconnected.

If we look at the Somatic emotions, this illustration reveals another unusual construction of the Telic function in which a high level of hedonic tone is maintained despite wide variation in arousal. This relationship is therefore inelastic in nature. At high levels of arousal it becomes extremely elastic and a dramatic fall in hedonic tone is experienced. Excitement seeking is foreign to them and in this sense a paratelic function is either absent or their capacity to experience paratelic emotion is diminished.



These are rigid people without the flexibility to adapt to circumstances because generally their self awareness is very limited. They feel positive about giving in emotionally important relationships and will allow others to "take" from them. They will expose themselves to one sided transactions of this kind until it goes too far for them to tolerate.

This raises the structure of Transactional emotions, illustrated in this slide. It depicts, in the allocentric mode, the ease with which they may experience guilt and the effort required to sustain a sense of being virtuous. It also indicates the dramatic fall in hedonic tone at very negative FTO should a reversal from allocentric to autocentric motivation occur. It is this combination of high arousal, extremely negative FTO and a reversal from the usual allocentric mode to the autocentric mode which may explain the dramatic, explosive homicidal assaults.



An example of this is the case of a young homosexual man whose partner teased him with infidelity constantly. On one occasion his partner brought another man home and had sex with him while the three of them sat in front of the television. When the couple were alone the partner made adverse comparisons about the sexual performances of the patient and the other young man. He remembers very little of what happened in the next few minutes, but the pathologist reported almost one hundred stab wounds in the body of his partner. His capacity to tolerate extreme provocation, or extreme negative FTO had simply reached its limit. He experienced a reversal from his usual orientation towards others, to a primary concern about how these transactions influenced him.

Therapeutic considerations in someone like this must be to help him identify stressful situations and transactions for what they are and to develop strategies other than self sacrifice in dealing with them. He needs to reverse into autocentricity sooner. This may require fundamental reappraisal of what is of significance for him, such as the urgent need to sustain a dependent relationship at almost all cost.

6 REVERSAL THEORY AND PSYCHOPATHOLOGY

Several kinds of psychopathology emerge from these formulations of mentally abnormal offenders. Each one carries with it implications for treatment and provides a dimension to consider in relation to the predicting of dangerousness.

6.1 Inhibited Reversals

Inhibited reversals are comparable to Millon's notion of "adaptive inflexibility". The individual is stuck in one mode so that they become frustrated and remain serious when others want to have fun; or continue to be frivolous when others are serious. Alternatively, anti-social characters may be unable to move from being self interested to being concerned about others with the result that they are trapped between humiliation and pride. We have all had periods of being self centred and only come to realise it when something dramatic happens to illustrate our limitation. Normally this is not pathological but it marks times of discomfort and distress in our lives.

The therapeutic endeavour in patients of this kind is to facilitate more frequent and earlier reversals. One client who I have written about (Thomas-Peter 1992) simply had no access to thoughts which might inhibit his behaviour at times of high excitement. Making the connection between his intended behaviour of stabbing women in the stomach and the consequences of this in the laboratory, caused him to be physically sick with emotion. We were able to precipitate a reversal from paratelic to telic motivation with the result that the high arousal became unpleasant.

6.2 Diminished emotional repertoire

This is different from those who simply do not have the capacity to experience certain emotions. Among the overcontrolled group I have hypothesized the absence of excitement seeking. Among the primary psychopaths I have hypothesized an absence or diminished capacity to experience transactional emotions associated with concern about others.

It may be futile to seek to establish "new emotions" in these circumstances. I have heard many people talk of techniques such as "empathy training" and my suspicion is that it amounts to shaping verbal behaviour, leaving the underlying pathology unscathed.

Therapeutic considerations for people of this kind is probably best directed towards developing non-aggressive coping strategies, working within dominant motivational states. This can be supplemented with relapse prevention type work, involving self monitoring and situation management providing there is sufficient motivation to work for their own long term interests.

6.3 Disinhibited Reversals

There are also those whose life is disrupted by the inability to sustain the effort required to achieve important goals. They can easily be knocked out of equilibrium. Millon describes characteristic of psychopathology as being a problem of "tenuous stability" and it may be reflected in Cleckley's (1976) concept of "failure to follow a life plan" among psychopaths. In RT terms this might be described as inappropriate or disinhibited reversals.

The contribution which reversal theory makes to this concept is that it indicates the predominant mode within which someone functions, but also the likely motivational consequences of being in a non-dominant mode. We will all have examples of people who have presented as being perfectly well adjusted while incarcerated, but motivated to commit serious acts of aggression when in the community. Perhaps we fool ourselves by limiting our assessment to stable dispositional characteristics of the client. Reversal theory allows us to systematically consider, inconsistency and discontinuity of behaviour, which so often is the key to understanding offending.

6.4 Abnormal elasticity

Finally, the shape of the functions which describe the relationships between how good one feels and either arousal or FTO seem crucial to understanding psychopathology. Among psychopaths the hypothesized "bull horn" appearance of the relationship between arousal and hedonic tone distinguishes them from other groups. This combined with the unusual lopsided transactional emotions may make the constellation of emotions unique. The structure of emotions may be equally unique for the overcontrolled group. It seems likely that different personality disorders will have distinctive constructions.

7 CONCLUSION

This paper is an attempt to introduce Reversal theory into the discussion of personality disorder and sadistic aggression. It generates testable hypotheses about the structure of emotion and the experience of offending. It also implies therapeutic targets. The shape of these curves actually represent the accumulated values, rules, beliefs and expectations of people. It is therefore probable that the most successful means of altering the shape of the curves is through innovative forms of cognitive therapy. The theory offers a phenomenological framework for considering both change in those we are trying to help, and considering risk to those we are trying to protect. As a psychologist I am attracted to these properties. It makes me feel optimistic about finding a way forward.

I want to offer Reversal theory, not as an answer to a question, but as a beginning of a process. For me it is a return to the rigour of a systematic process of theory, hypothesis generation and testing. We should not be deflected from this by debates about civil liberty and protecting the public; or those debates about madness and badness; or those about who should own and control the patient. We must also resist the temptation for a quick fix, the "package deal" of behaviour or cognitive therapy. Reversal theory provides an opportunity to be creative and purposeful in describing and classifying the people and exploring the problem. It has a long way to go before its worth is established and I look forward to the exploration of these and perhaps other ideas.

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TRAINING AS TEAM BUILDING IN CORRECTIONS

BY

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TRAINING AS TEAM BUILDING IN CORRECTIONS

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Implementation of mental health interventions within correctional environments requires the services of skilled clinicians and the support of institutional staff. Experience demonstrates that the support of correctional officers is improved when staff are offered informative, practical training concerning mental health issues. Training can be an effective tool in developing a "team" approach to correctional mental health care.

Standards of the American Correctional Association and the National Commission on Correctional Healthcare require training of correctional staff in the following mental health areas:

- * Recognizing the need for emergency care in life-threatening situations (e.g., potential suicide).
- * Recognizing acute manifestations of certain chronic conditions (e.g., seizures, intoxication and withdrawal, and adverse reaction to medication).
- * Recognizing other chronic conditions (e.g., mental illness and developmental disability).

While the training material required by accreditation standards provides correctional staff critical mental health information, comprehensive mental health programs have supplemented this basic training with additional material. Training of institutional staff in interpersonal communication, stress management and the unique needs of segments of the incarcerated population (i.e., female inmates, chronically mentally ill inmates) has provided avenues for mental health staff to share information and develop rapport with correctional staff. Further, in-depth training of correctional staff in the goals and operations of specialized mental health programs (e.g., substance abuse treatment, extended care for mentally ill or cognitively impaired) prior to the implementation of the program has been linked to program success and effectiveness.

Effective mental health training of correctional staff requires more than accreditation mandates. If training is provided with minimal planning and little consideration of the target audience, the training can compromise rather than enhance the relationship between correctional and mental health staff. Correctional staff are required to attend a great deal of training annually. Mental health issues can be topics in which the staff has little interest or view as having limited relevancy to their day-to-day job performance. These attitudes, coupled with the fact that officers often attend training before or after a full shift of work, present the mental health trainer with a significant challenge.

Several factors can increase the chance of meeting the challenge of providing informative and entertaining mental health training experiences. One critical factor is the choice of the individual who is to provide the training. Other factors include the content of training, the method of presentation, and the on-going evaluation of the training program.

Not all mental health staff make good trainers. The optimal choice is an individual with an open communication style, an interest in providing training, and a comfort in presenting information to large groups. Mental health trainers must be able to interact with their audience as members of a team rather than as "mental health professionals" imparting "wisdom." If a trainer neglects rapport development, trainee interest and retention will be limited. Trainers also need to be able to interject humor into the training session, even occasionally "making fun" of themselves. Training modules are often developed to specifically outline presentation content, but effective trainers must be able to tailor this material to the needs of each training experience as the trainer develops an awareness of the dynamics of the specific group.

The content of mental health training must be perceived by the trainee as relevant to his/her functioning. Prefacing training with concrete examples of how the training pertains to institutional operations and everyday life can increase trainees initial interest in the material. The training modules should address specific goals rather than attempting to provide as much information as possible within the time allocated. Select the most important information and focus on these areas. Additional areas can be covered based on trainee interest.

Mental health training needs to be presented in pragmatic, "non-psychobabble" terms. Using clinical terminology which the trainees may not fully understand can "build a wall" between the trainer and the trainees. While the term "psychotic" elicits a clear picture for mental health staff, for the correctional staff it may seem like "psychobabble." When clinical terminology is critical to the training, ensure the trainees understand the term by defining the term in everyday language and using examples common to the audience.

Straight lecture should not be relied on for training in mental health issues. Trainee questions should be encouraged throughout the session as these permit the trainer to assess group understanding of the material and to determine issues needing further discussion. If there are correctional staff with experience in the material being covered, they should be integrated into the training experience as peer involvement can enhance trainee acceptance of the material.

Adults need material presented in several mediums for optimal learning. The use of videos, overheads, slides and interactive experiences permits trainees to take an active role in the learning process. When videos are used, but videos should be chosen carefully for content not as "time-fillers." Videos should not be used unless they address the material being presented and can be used to promote discussion.

Role plays and use of trainees in exploring specific points of the training are important not only for explaining material but also for developing and maintaining rapport. For example, a technique used to provide trainees with insight into the effect of auditory hallucinations is to have three volunteers talk non-stop to a fourth unsuspecting volunteer while he/she is asked to carry on a normal conversation with the trainer.

Effective training of correctional staff in mental health issues is critical as it can impact the development of a partnership between security and treatment staff in the delivery of mental health services. Mental health staff should be carefully selected, trained and rewarded for their participation in the training efforts.

**CORRECTIONAL ADJUSTMENT SCALE AND
CORRECTIONAL ADAPTIVE RATING SCALE:
RELATIONSHIPS TO TREATMENT PLANNING
AND PROGRAM EVALUATION**

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ABSTRACT

The Correctional Adjustment Scale (CAS) and the Correctional Adaptive Rating Scale (CARS) were developed specifically for use with incarcerated inmates who have been designated as needing Mental Health services. These Scales offer objective and behaviorally-tied measures of global functional assessment and treatment efficacy.

The CAS is designed to provide functional assessment of mental health inmates. The evaluation of functionality spans three global domains (Bio-physical, Social-Intellectual, Behavioral-Emotional). Each of the global domains are divided into sub domains which contain descriptive and behaviorally related statements ranging from lowest to highest level of functioning.

The CARS was designed to parallel Axis V of the DSMIII-R (Global Assessment of Functioning). The CARS is divided into twenty (20) summary statements which each span a five (5) point interval, yielding a score which ranges from 0 to 100. The overall CAS rating is designed to fall within one of the descriptive categories in the CARS Instrument.

This paper will report the results of the initial application of the CAS and the CARS to the rating and classification of thirty (30) inmates who housed in a Level II, MH/MR supportive living unit in a medium to close security, state prison. Overall, inter-rater reliability and validity coefficients were significant and encouraging. Initial feedback from staff using the CAS and CARS suggests that they seem to have significant value in developing treatment plans and for facilitating the formulation of treatment goals. Implications for future research are discussed including the use of the CARS to assess the efficacy of a variety of treatment interventions in a mental health correctional setting.

Introduction

Measurement procedures for determining an individual's functional capacity have long been important in the context of the care and treatment of inmates (or patients) with mental health problems. Many of the important treatment and placement decisions that institutions make regarding mental health patients are based on the functional level of the individual in question.

Functional assessment among psychiatric populations has of course a much longer history than that of the correctional setting. There are a number of valid and reliable self-report and observer-rated instruments available (Baker & Hall, 1988; Bloom, 1975, and Goga & Hambacher, 1977). However, a closer examination of the appropriateness of these instruments in a correctional setting suggests that these scales do not readily lend themselves for use with mentally ill offenders. Other studies indicate that assessment of overall level of functioning has also been used with adolescent and geriatric populations (Campbell & Thompson, 1990). But again, these instruments clearly have limited use within the correctional setting. The chief difficulty with both the psychiatric and the adolescent/geriatric assessment tools is the domain of behaviors chosen for rating. The kinds of behaviors focussed on by these instruments have little relevance for adjustment in the correctional setting.

A recently implemented correctional classification system now being used in the authors' institutional setting also facilitates decisions regarding placement of inmates. This system, developed by Quay (1984) is referred to as the Adult Inmate Management System (or the "AIMS" scale). The AIMS instrument is more pertinent to the security classification system and is used to determine the housing needs of the general population inmate (Quay 1984). The AIMS system is valuable for stratifying inmate populations in regards to adjustment to various housing arrangements or living quarters. However, in terms of global functional assessment with mental health patients/inmates the AIMS system also falls short. What is needed, it seems, is a system that is highly descriptive and that lends itself to decision making, treatment planning and program evaluation within the mental health-correctional environment.

In the typical correctional setting, there is a great need for objective criteria by which decisions about the suitability of an inmates placement in various treatment programs, housing situations and job and institutional assignments can be made. Further, evaluation of the efficacy of treatment interventions; measurement of treatment goal attainment, and determination of overall behavioral improvement must be made within the correctional setting. There is little other than subjective clinical judgment that can be called on for assistance in these critical decisions.

The institutional setting within which the CAS and the CARS were developed utilizes the Diagnostic and Statistical Manual of Mental Disorders III-R (DSM III-R, 1987) to

perform Global Assessment of Functioning (Axis V) on inmates with mental health problems. This scale permits the clinician to evaluate the patients' psychological, social, and occupational functioning. These ratings are typically made in reference to two time periods, first, at the time of initial evaluation and secondly, for the past year (DSM III-R, 1987). In the typical correctional setting, functional assessment tends to be made in reference to the previous week. There is a tendency for this rating to be consistently higher than ratings provided by the multidisciplinary team using the CAS and the CARS. The rating period for the CAS and the CARS cover from one week to six months.

Any discussion of level of functioning or adaptability must carefully consider the relevant characteristics of the mental health population. In 1965 the American Association of Mental Deficiency (AAMD) implemented a project to study the dimensions of "adaptive behavior". This project produced two adaptive behavior scales (Nihira et al., 1969), one designed for children aged 3 through 12, and the other for people 13 years of age and older (AAMD, 1975). These scales were revised in 1974 (Nihira, Foster, Shellhaas & Leland, 1974). The purpose of the 1974 scale was to provide objective descriptions and evaluations of an individual's effectiveness in coping with the natural social demands of the environment. When it was recognized that functioning in various social environments requires specific evaluation, a public school version of this scale was developed (Patton, Smith, & Payne, 1990). The AAMD adaptive behavior scales have proven to be of great value in the assessment of the adjustment of the mentally handicapped individual in the community and school settings.

However, as with similar instruments, the adult version does not readily generalize to the correctional setting. Furthermore, most of the patients/inmates needing functional assessment in the correctional setting do not fall within the classification of mentally handicapped. What is required in the mental health correctional setting is an instrument that can be used with a much more heterogeneous population. The range of behaviors, levels of adjustment and degrees of social competence are in fact quite extensive among the typical mental health correctional population.

The Vineland Social Maturity Scale (Doll, 1953) is another example of an excellent adaptive behavior scale. It has been revised a number of times, most recently in 1984 and was renamed The Vineland Adaptive Behavior Scale (Sparrow, Balla, & Cicchetti, 1984). The original premise of the Vineland was to provide a measure of social competence and social maturity. These constructs were chosen to assist the examiner in diagnosing mental deficiency within a social context (Patton, Smith, & Payne 1990). Because of its design and measurement properties, the Vineland (like the AAMD Adaptive Behavior Scale) is not well suited for use in the correctional setting.

Other attempts to assess functionality and psychopathology with mentally handicapped persons include the work of Sturmey and Ley. The Psychopathology

Instrument for Mentally Handicapped Adults (PIMRA), (Matson et. al., 1984; Senatore et. al., 1985; and Sturmey & Ley, 1990) is a 56-item instrument with eight scales corresponding to DSM-III classifications (DSM III, 1980). Matson, (Matson et al. 1984) and Senatore (1985) reported that the PIMRA had adequate internal consistencies, as well as test-retest reliabilities, and a factor analysis yielded three factors: "affective", "somatoform", and "psychosis". Sturmey and Ley (1990) found the internal consistency of the scales to be barely acceptable and much lower than previous studies had reported. It appears that the PIMRA needs more work and again, it does not satisfy the needs of the correctional setting for a tool that provides objective functional assessment and program evaluation.

Other relevant literature indicates that some clinicians are using the Global Assessment Scale (GAS) to develop treatment plans and to monitor behavioral change with adult psychiatric patients (Kuhlman, Sincaban, & Bernstein, 1990). The GAS was originally designed for use by a single rater, and was intended as a measure of the overall severity of psychiatric disturbance (Endicott, Spitzer, Fleiss, et al, 1976). Kuhlman, Sincaban & Bernstein (1990) expanded the use of the GAS to include individual ratings made by members of a multidisciplinary team which were then averaged to provide a team rating. The scores for the individual patients, the changes in scores over time and the average score for the ward offer a method for objectively expressing the patient's levels of functioning (Kuhlman, Sincaban, & Bernstein, 1990).

The GAS as used by Kuhlman, Sincaban,& Bernstein, incorporated several procedures that have appeal for use in the correctional setting. First, the use of multiple ratings across treatment team members could give more balance to functional assessment. Secondly, the ratings can be compared against subsequent ratings to objectively express improvement or deterioration. In the present study, these procedures were incorporated in the design and use of the CAS and the CARS.

Development of CAS and CARS

In developing the CAS and The CARS the authors used the following environmental/situational factors as criteria for design: First, the correctional setting demands that patients/inmates be able to perform daily duties and responsibilities. Therefore, functional assessment is necessary to accurately ascertain the capabilities of each patient/inmate. Secondly, patients/inmates perform their daily duties throughout a variety of settings. Thus, assessment should span across the various settings and the instrument developed must be usable by all staff supervising inmates. Third, the authors current work setting uses a classification system based on the DSMIII-R Global Assessment of Functioning.

The DSM III-R ratings are done by the consultant psychiatrist/ psychologist and require extensive training that is not available to staff members. The CAS and the CARS, on the other hand, can easily be completed by any correctional staff. All that is

needed to rate an inmate is observational knowledge of the inmates' performance of some duty in a particular situation. Additionally, the CARS was designed to parallel the DSM III-R levels of functioning so as to maintain continuity in ratings that could facilitate treatment decisions and placement decisions.

The DSM III-R global assessment spans situational variables but does not incorporate the concept of global team ratings (as presented by Kuhlman, Sincaban, & Bernstein, 1990) as used in our rating system. To develop items for the CAS, team members were given the following global domain areas (Bio-Physical, Social-Intellectual and Behavioral-Emotional) and asked to develop a list of subdomain areas for which descriptive and behaviorally oriented statements were generated. The final design of the CAS uses seven subdomain areas for the assessment of bio-physical functioning (Orientation, Sleep/Eating Disturbance, Hygiene and General Health). The global domain of social-intellectual functioning includes six subdomains (Reality Testing, Motivation, Social Competence, and Peer/Staff/Authority Interaction). The third global domain of behavioral-emotional functioning includes seven subdomains (Suicidal Ideation, Perceptual Disturbance, Affective Disturbance, Anxiety, Emotional Control, Compliance with Treatment Plan, and Independent Functioning).

Each subdomain includes five descriptive statements that span from least functional (zero) to greatest functioning (five). There are a total of twenty subdomain areas each with a maximum rating of five. The sum of the subdomain ratings yields the individual and team average ratings which fall into one of ten descriptive ranges. Total adjustment would then be indicated by an average rating on a scale from zero to one hundred. The CAS is designed to provide baseline and time-lapsed evaluation of specific behaviors and to aid in treatment planning and program evaluation. The CARS intervals span the entire range of functioning of MH/MR inmates within the typical correctional setting and is intended to objectify evaluation of treatment outcomes and subsequent placement decisions.

Method

Thirty (30) MH/MR inmates were randomly selected from an MH/MR Supportive Living Unit (SLU) in a medium to close security state prison. In this setting inmates will have a DSM-III Axis I diagnosis as assigned by a licensed clinical consultant. The inmates used in this study are considered Level II-MH/MR patients. These inmates encompass the vast majority of inmates assigned as MH/MR. Inmates could be classified from Level I (no services or outpatient on maintenance medication) to Level IV (needing immediate psychiatric hospitalization). Level II- MH/MR inmates are described by the CARS as follows: At the more functional end of the Level II continuum, moderate symptoms and/or functioning with some difficulty, most untrained persons would consider the inmate as disturbed. At the most severe stage on the Level II continuum, inmates/patients exhibit major impairment in several areas, such as interpersonal

relationships, judgment, reality testing, communication, or thinking (e.g. neglects personal hygiene, unable to perform assignments, speech is illogical or irrelevant, or has made a recent suicide attempt).

Inmate's were included regardless of their current diagnosis. Diagnosis ranged from chronic schizophrenia to mild mental retardation. Many of the inmates in this study are dual-diagnosed with personality disorders as well. Nineteen inmates (63%) were Black and eleven (37%) were white (this ratio very closely parallels the Black to white ratio of the entire institution to which the inmates were assigned). Ages of the sample ranged from 21 to 56 years, with a median age of 31. The amount of time served ranged from 1 year to 19 years, with an average of 5.4.

As can be seen in Table 1, the IQ scores of the sample ranged from 57 to 122, with a mean of 90.17. Seven inmates were classified as "mentally defective" (IQ below 70) and four inmates scored above IQ's of 110. The other 19 IQ's fell within the average range. Educational level ranged from below 3rd grade level to above grade 13 (1st year college). Two inmates were high school graduates and two had earned GEDs.

Insert Table 1 about here

Individual ratings with the CAS were performed for all inmates/patients by the building officer (from the Supportive Living Unit), primary therapist (counselor), activity therapist and the consulting psychiatrist. All ratings were independent. That is, no rater had knowledge of any of the other team members ratings. Further, no rater had knowledge of the numerical weighting of individual descriptive statements or of their relationship to final classification. Using these ratings, inter-rater reliability was computed by comparing the ratings of the various independent judges. Concurrent validity was assessed by comparing current CAS/CARS ratings with current DSM III-R ratings. Degree of concordance among the judges was compared, and a measure of "hits/misses" was obtained by determining how many team ratings fell within the MH/MR Level II classification system on the CARS).

Results

Evaluation of the reliability and validity properties of the CAS/CARS revealed highly significant results. Inter-rater reliability was assessed by calculating Pearson's r's for the various combinations of raters. These associations are graphically displayed in Table 2.

Insert Table 2 about here

Inter-rater correlation coefficients were also calculated between pairs of raters (counselor-activity therapist, counselor-building officer, and activity therapist-building officer). All were found to be highly significant as well. Coefficients for pairs of raters ranged in significance from $P < .025$, to $P < .005$.

Measures of concurrent validity were assessed using Pearson's product moment correlation method. Ratings based on the CAS/CARS instruments were compared to ratings with the DSM III-R global assessment of functioning scale. All coefficients were highly significant ($P < .005$). Regression analysis with the ordinary least squares method were run to assess the ability of staff using the CAS/CARS instruments to predict ratings made by a licensed consultant. This analysis reveals a highly significant level of predictability between the CAS/CARS instruments and the DSM III-R global assessment of functioning. Inmates assigned as level two mental health with the CAS/CARS can receive ratings from forty (40) to fifty nine (59). Therefore, an additional measure of the scales usefulness is the degree to which the CAS/CARS instruments can appropriately identify and place inmates. To assess the extent that ratings resulted in appropriate classification (e.g. inmates given appropriate Mental Health Level designations), a percentage of "hits" and "misses" was calculated. It was considered a hit when the average of the three raters (counselor, activity therapist, and building officer) placed him in a MH/MR Level II category. Using this approach, 23 inmates (77%) were correctly "categorized", suggesting that using the CARS as a placement instrument seems to be justified. Further, when the ratings of the consulting psychiatrist (using the DSM-III-R Global Assessment of Functioning) were included, the percentage of correct classifications ("hits") increased to 25 (83%). Thus, of 30 global team ratings, 25 were correctly designated by the multidisciplinary team. This seems to lend support to the validity of the CAS/CARS instruments as a placement tool by the treatment team. It is interesting to note that the five inmates who were not correctly classified ("misses") were all classified as above the cut-off selected for MH/MR Level II inpatient status.

Discussion

Results of the present investigation are strongly supportive of the usefulness of two instruments as assessment techniques in a correctional setting. The Correctional Adjustment Scale (CAS) and the Correctional Adaptation Rating Scale (CARS) were developed and applied to a sample of 30 inmates in a Mental Health Supportive Living Unit.

Correlational analysis indicates that both instruments have adequate reliability and validity. Staff feedback suggests that communication among team members was greatly enhanced as well as a significant improvement in formulation of treatment goals. It is hoped that further analysis will support the utility of the two instruments in program evaluation and appropriate placement decisions.

Future research will be directed toward further validation and refinement of the two instruments. The first objective will be to cross validate the present findings with a second sample of Level II MH/MR inmates. The second objective will be to determine the degree of discriminant validity of the two instruments by obtaining ratings of samples of Level I and Level III inmates from two other correctional facilities for comparison with the Level II inmates available in our institution. Thirdly, we hope to use the ratings of the CAS and CARS to uncover significant and possibly predictive relationships with covariables such as IQ, achievement level, number of disciplinary reports, etc. And finally, we intend to develop a manual to assist in the formulation of treatment goals utilizing the various dimensions of the CARS and to factor analyze the items of the instruments to determine the patterns or clusters within the two scales.

	Counselor CAS Rating	Activity Therapist CAS Rating	Building Officer CAS Rating	Psychiatrist CARS Rating
Means =	48.93	48.40	51.37	61.83
Std. Dev. =	10.82	9.42	8.56	10.62

	Culture Fair IQ	WRAT-Read	WRAT-Total	Age
Means =	90.17	6.67	6.04	33.79
Std. Dev. =	18.76	2.59	3.28	7.81

Means and Standard Deviations for Counselors, Activity Therapist, and Building Officer on the CAS and the Psychiatrist on the CARS; IQ Scores, WRAT Scores

Table I

Counselor with Activity Therapist	.39 *
Counselor with Building Officer	.55 **
Counselor with Psychiatrist	.47 **
Building Officer with Activity Therapist	.51 **
Building Officer with Psychiatrist	.56 **
Activity Therapist with Psychiatrist	.50 **

* P < .025 ** P < .005

Pearson Product Moment Correlations Among Raters Using the CAS or the CARS

Table 2

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MENTAL HEALTH CRISIS INTERVENTION TEAMS:
PREVENTION AND INTERVENTION

BY

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Presenter:

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**MENTAL HEALTH CRISIS INTERVENTION TEAMS:
PREVENTION AND INTERVENTION**

One of the major continuing concerns of mental health care providers in corrections is the incidence of suicide and other self destructive behaviors displayed by inmates in jails and prisons. Suicide is often called "the preventable death". The utilization of mental health crisis intervention teams have been proven to be effective in the early intervention and prevention of self-destructive behaviors in inmates. The effectiveness of carefully selected crisis intervention teams, whose members are well-trained to identify and respond to the early signs of inmates in crisis, have been shown to decrease dramatically the extent of self harm and lethal behaviors actually carried out by those inmates in crisis, whether they be adults or juveniles. This presentation is designed to outline relevant issues to consider when selecting members for a mental health crisis intervention team in order to maximize the effectiveness and cohesiveness of the team. In addition, concepts which are important to the success of the on-going crisis intervention team training program and elements of effective crisis intervention team activities must also be considered to maximize the effectiveness of the efforts of the team.

When we review the data on detainee or inmate deaths in jails and prisons across the country, we find that the percentage of deaths by suicide for inmates in jails is approximately 40%, while the percentage found in prisons is approximately 6-7%. While the rate of death by suicide in prisons is far lower than the rate found in jails, even a 6-7% level of deaths by suicide is deemed unacceptable. If we translate that 6-7% into actual numbers, we are talking of approximately 1,500 inmates nationwide per year who die a "preventable death". Since all of us are clearly motivated to reduce the suicide rate in our jails and prisons to as close to zero percent as possible, it is important that we look at ways to more creatively utilize the resources that we do have in our jails and prisons, especially in these times of ever-decreasing resource availability.

One method which has been found to greatly reduce the number of serious incidences of suicide gestures attempts and self mutilating behaviors is the development and implementation of mental health crisis intervention teams. It is important to understand the basic issues in team design and selection of members for the team. Basically the mental health professional serves as the crisis team leader with nursing staff and security staff serving as the other two legs of a three-legged stool. It is important to have well trained nursing staff as members of the crisis team given that suicide precautions and utilization of therapeutic restraints

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and medication should be provided under the supervision of medical staff with orders from psychiatry. Security staff is essential since the safety and well-being of inmates as well as staff members rest in their hands. The management of inmates who are dangerous to themselves or others due to mental illness or emotional upset, which may even be the result of character disorder, is important to coordinate with security staff with their utmost support and contribution to creative interventions.

Individual characteristics of the various team members need to be considered in the areas of age, sex and body size. For example, to have all security officers be white, male, under the age of 30 and very large in body size can serve to impact inmates in a negative way in that all security officers are scary authority figures. Level of authority of the individual and their job title should be considered also when selecting crisis intervention team members. The highest level of authority in that particular job area should be selected, because these people are the decision makers. For example, in the security staff area, officers who are of Lieutenant rank or above are preferred over line-security staff who can be over-ruled by their supervisors. In the area of nursing, R.N.'s as opposed to L.P.N.'s should be selected since charge nurses can over-rule decisions made by floor nurses. The mental health professional who is on-call for that day would be designated as the crisis team leader and other mental health professionals should acknowledge and support that position and not over-rule the leader but work through that person with new information as it becomes available. The success of the selection, training and implementation of a crisis intervention team is determined at the top administrative levels in your institution or correctional system. Without support of the top authorities for the implementation of this type of program, it is doomed to failure. As is true with many programs in corrections, it is a top-down approach which appears to be most effective.

An additional individual characteristic which is extremely important is the experience level an individual may have in working with the mentally ill or emotionally disturbed and also the comfort level they may have with difficult types of inmates. Not all security officers or nursing staff have experience, or if they do, they may not be very effective with this type of inmate. Many years of experience does not equate to a great degree of comfort and it should be assessed carefully in the selection of crisis team members. Other personal qualities which are important and should be focused upon when selecting crisis team members includes an empathic style and a willingness to listen and understand what inmates are trying to say. It is also important that this individual present a calm demeanor and be able to think well under pressure. While all of us may feel extremely anxious at these moments and feel like we are paddling frantically underneath, a calm, confident, and cooperative demeanor is important. While some persons employed at your

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institution may be very confident and skillful in some of these areas, but are not good team members in other situations, probably would not make a good crisis intervention team member. It is very important that persons who work on a crisis intervention team be able to cooperate and compromise when it comes to deciding on a treatment intervention in which the needs of the inmate can be met without compromising the needs of the institution. Sometimes this requires creative negotiations among team members and if this becomes a power struggle, the team is defeated before it begins. Even if persons have had little or no previous experience working with the mentally ill or the emotionally disturbed but they do demonstrate basic, solid personal qualities and also exhibit a willingness to learn, this individual will probably be a good person to select for a mental health crisis intervention team.

It is important that basic training for 8-16 hours take place in the early development of crisis intervention team members, preferably provided by a mental health professional trained in this area. While we could enumerate many skills which need to be developed in each crisis intervention team member, a starting place in training is to explain at least one model of crisis intervention. One such model which has been successfully utilized in this type of training has been an explanation of the stages of the crisis experience. We can use ourselves as examples in something as commonplace as discovering a flat tire when trying to leave for work in the morning. A discussion of prior functioning before the barrier which precipitates a crisis and the disorganization which then follows can lead to the decision of which crisis interventions can be most effective. During the period of time called the "angle of recovery", depending on the quality and quantity of the intervention, an individual can be returned to at least the prior level of functioning and hopefully even higher. When interventions have been minimal or ineffective, the individual becomes reorganized at a level of functioning which is less than prior functioning and may even precipitate into another crisis in the near future. Numerous other models are described in the books listed in the bibliography and brief outlines of these models are indicated in the handout today.

Basic communication skills are essential to any crisis intervention team training program. The focus should be on how to form a relationship, listen and communicate while instilling hope with this inmate in a correctional setting. How a mental health professional or someone in a helping field might do this in corrections will differ from how this may be done in the free community and these basic differences are essential to outline and compare. For example, the "therapeutic" relationship that the mental health professional doing crisis intervention with an inmate in corrections would be different from that of a security captain who is establishing a "therapeutic" relationship with an inmate through artful listening. Appropriate communications and instilling hope can be enhanced

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by his or her confident manner. In addition, nursing staff creates a different "therapeutic" relationship because of the nature of the medical profession, the direct line to the physician, and the absence of a security function. Again these trained professionals must learn to form a relationship which facilitates inmates personal reorganization and do this in keeping with their role in the facility as well as with their professional role. Specific examples should be given and role-played for most effective training.

Other basic intervention skills need to be selected based on a needs-assessment of the institution and of that crisis team. Ideally, crisis intervention team members and others who work along side them will identify at a early stage inmates who are in need of intervention and do this before a full-blown crisis is in progress. Crisis intervention team members should be trained to focus on prevention rather than intervention as their primary goal. All of the individual and team skills are utilized with varied emphasis in doing prevention, intervention and also post intervention work. These individual and team skills include: interpersonal skills, assessment of individuals in situations, intervention plan development, action plan implementation, monitoring of plan implementation, and follow-up treatment. Even when a crisis intervention team is involved in a preventive intervention, an intervention plan needs to be developed and implemented as well as monitored with a followup component. Something prevention activities are given the short shrift and the severe crisis occurs anyway, either then or at a later point in time. Crisis intervention team members then get discouraged and will claim "this doesn't work", when in fact it may be due to lack of complete training and understanding of the tasks. Trained crisis intervention team members understand well the importance of communicating to their colleagues on all shifts, what the concerns are and what has been implemented to date, so that interventions can be monitored and carried out successfully and uniformly across shifts and for several days so that adequate follow-up and closure can be achieved.

This presentation gives a thumb-nail sketch of issues to consider when placing, selecting and training correctional medical and mental health staff members for service on mental health crisis intervention teams in prisons and jails.

Midwestern Mental Health in Corrections Symposium Overview

Steering Committee: Bruce Leeson, Ph.D.; Hodges Glenn, Ph.D.; Donald Denney, Ph.D.; Mark Skrade, Psy.D.; John Worley, Ph.D.

Agenda Planning Committee: Jane Haddad, Psy.D; Nadine Belk, Ph.D.; Jacqueline Buck, Ph.D.

Faculty Selection Criteria

Vita of all presenters will be forwarded to the Sponsoring Agency. All presenters must demonstrate in their written materials and vita's the level of competence and professional experience that suggests expertise.

Needs Assessment

Issues for the Mental Health in Corrections symposium will be based upon previous symposium feedback, institutional input, professional experience and the opinions and preferences of both the steering committee and the agenda planning committee. A needs assessment will be conducted in conjunction with the current symposium.

Participation Satisfaction Evaluation

The attached feedback form will be provided to each participant during the registration process. Summary data will be collected and reported within two weeks of the accomplishment of the symposium (June 12, 1992). Copies to be forwarded to steering and agenda planning committee members, the sponsoring agency, and the executive officers from the hosting agencies.

Learning Assessment

Participants will be provided with a list of the learning objectives for each presentation and will be asked to assess the accomplishment of these objectives.

Use of Evaluations to Improve Program

At the conclusion of the symposium, each participant will be asked for their suggestions for the 1993 symposium. This feedback will be integrated into the 1993 symposium.

Development of Learning Objectives

Each presenter will be asked to provide a list of learning objectives. These objectives will be reviewed by the agenda planning committee.

Co-Sponsor Agreement

The co-sponsorship agreement is attached.

Sample Certificate

The certificate that will be used to document the number of CE credits earned is attached.

Grievance Policy

A list of grievance policies will be posted at the registration desk. The grievance policy is attached.

**CO-SPONSORSHIP OF APA CONTINUING EDUCATION ACTIVITIES
LETTER OF AGREEMENT**

This Letter of Agreement is made between the:

Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas
and
the United States Disciplinary Barracks, Fort Leavenworth, Ft. Leavenworth, Kansas
and
the Psychology Services, United States Penitentiary, Leavenworth, Kansas,

and is designed to explicate the policies and procedures that will govern co-sponsorship of activities for which APA Continuing Education Credit will be awarded.

This agreement extends from January 1992 to January 1993.

1. The Director of Training of the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas and the Mental Health in Corrections steering committee will assume responsibility for the content of the approved training endeavor.
2. In collaboration with the Mental Health in Corrections steering committee, the Director of Training of the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas will be responsible for:
 - a. the development of learning objectives
 - b. the selection and evaluation of faculty
 - c. development of curriculum content
 - d. design and implementation of evaluation
 - e. development of standards for awarding CE credit; and
 - f. assurance of adequate fiscal resources for the successful conduct of the activity.
3. The Mental Health in Corrections steering committee assures that it will work with the Director of Training of the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas to assure that all training activities adhere strictly to the ethical principles of the American Psychological Association.
4. The Director of Training of the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas will review all promotional materials prior to printing and dissemination to further assure adherence to the ethical standards of the American Psychological Association.

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Midwestern Mental Health in Corrections Symposium Grievance Policy

The Mental Health in Corrections symposium in cooperation with the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas is fully committed to conducting all activities in strict conformance with the American Psychological Association's Ethical Principles of Psychologists. The Mental Health in Corrections symposium will comply with all legal and ethical responsibilities to be non-discriminatory in promotional activities, program content and in the treatment of program participants. The monitoring and assessment of compliance with these standards will be the responsibility of the Director of Training from the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas in consultation with the members of the continuing education committee and the Mental Health in Corrections symposium steering committee.

While the Mental Health in Corrections symposium and the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas goes to great lengths to assure fair treatment for all participants and attempts to anticipate problems, there will be occasional issues which come to the attention of the symposium staff which require intervention an/or action on the part of the symposium staff or the Director of Training from the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas. This procedural description serves as a guideline for handling such grievances.

When a participant, either orally or in written format, files a grievance and expects action on the complaint, the following actions will be taken.

1. If the grievance concerns a speaker, the content presented by the speaker or the style of presentation, the individual filing the grievance will be asked to put his/her comments in written format. The Training Director and a member of the steering committee will then pass on the comments to the speaker, assuring the confidentiality of the grieved person.
2. If the grievance concerns a workshop offering, its content, level of presentation, or the facilities in which the workshop was offered, the Training Director or a member of the symposium steering committee will mediate and will be the final arbitrator. If the participant requests action, the symposium steering committee will:
 - a. attempt to move the participant to another workshop;
 - b. provide a partial or full refund of the workshop fee. A written note documenting the grievance for recording keeping purposes is necessary. The note need not be signed by the grieved individual.
3. If the grievance concerns the Mental Health in Corrections symposium or the Dwight D. Eisenhower VA Medical Center, Psychology Service, Leavenworth, Kansas program, in a specific regard, the Training Director or steering committee members will attempt to arbitrate.

**Midwestern Mental Health in Corrections Symposium
CONTINUING EDUCATION FORM**

In order to receive Continuing Education (CE) credits, you must do the following:

- a) sign-in on the attendance sheet in the morning and again in the afternoon;
and
- b) complete and return the attached form at the end of the symposium.

List 2 elements of information you learned in each presentation.

A. William Rold, J.D.: Opening Arguments: Legal developments in the constitutional right to mental health services.

- 1.
- 2.

B. LUNCHEON PRESENTATION - Brian Thomas-Peter, Ph.D.: Mental Health in United Kingdom Corrections.

- 1.
- 2.

C. KEYNOTE PRESENTATION - William Pithers, Ph.D.: Relapse Prevention in the Treatment of Sexual Offenders.

- 1.
- 2.

D. Jan DeLipsey, M.Ed.: Male sexual victimization: A review of empirical and clinical data of sexually abused males and its relationship to assaultive and/or criminal behavior.

- 1.
- 2.

E. James LaBundy, L.C.S.W., M.S.: The Offender's Project Model of Out-patient treatment of Sexual Offenders.

- 1.
- 2.

F. Jeanie Thies, Ph.D. & Rodney Clossum, M.A.: Differential models of relapse prevention training: A community supervision plan.

- 1.
- 2.

G. KEYNOTE PRESENTATION - G. Alan Marlatt, Ph.D.: The Relapse Prevention Model.

- 1.
- 2.

H. William Marek, Ph.D.: RET, the Criminal Personality and Relapse Prevention: In-custody treatment to reduce recidivism.

1.

2.

I. Carolyn Cordasco, M.Ed. & Paul Kovolew, M.S.: Sexual Offender Accountability and Responsibility (SOAR).

1.

2.

J. Maj. Lewis Mackey, M.S.W. & Bruce Leeson, Ph.D.: Relapse models applied to the treatment of assaultive offenders.

1.

2.

K. LUNCHEON PRESENTATION - G. Alan Marlatt, Ph.D.: Harm Reduction and the Relapse Prevention Model in Applied Settings.

1.

2.

L. Valerie Lorenz, Ph.D.: Pathological Gambling.

1.

2.

M. Dale Hoke, M.S. & Eugene Petersen, M.A.: An In-patient Mental Health Unit within a State Correctional Center for Female Offenders.

1.

2.

N. Gail Williams, M.D. & Marcia Haynes, R.N.: Development of the Mental Health Unit: Oklahoma DOC.

1.

2.

O. Marcia Haynes, R.N. & Annice Jo Steen, Ph.D.: Relapse Prevention in the Oklahoma Mental Health Unit.

1.

2.

P. Margaret Severson, J.D., M.S.W.: Redefining the boundaries of mental health services: A holistic approach to improving the mental health of inmates.

1.

2.

Q. James DeGroot, Ph.D.: Hurdles to the implementation of treatment programs in correctional settings: A constructivist's ruminations from a maximum security prison.

1.

2.

R. Nan Cothran: Relapse Treatment Unit.

1.

2.

S. Thomas Hayes, Ph.D.: Criminal Personality and Substance Abuse: Interactional Issues for Intervention Programs.

1.

2.

T. John Cameron, Ph.D. & Steve Larkins, M.S.: Relapse Prevention Model within Missouri Substance Abuse Treatment Programs.

1.

2.

U. Brian Thomas-Peter, Ph.D.: A structure of emotion in psychopaths: A motivational analysis of sadistic aggression.

1.

2.

V. Jane Haddad, Psy.D.: Training as team building in corrections.

1.

2.

W. Joseph Lane, Ph.D. & Thomas Pedigo, M.S.: Correctional Adjustment Scale and Correctional Adaptive Rating Scale Relationships to treatment planning and program evaluation.

1.

2.

X. Jacqueline Buck, Ph.D.: Mental Health Crisis Intervention Team: Prevention and Intervention.

1.

2.

Y. William Rold, J.D.: Closing Arguments: Delivery of mental health treatment to inmates.

1.

2.

Z. James Fitzsimons, Donald Murray, Ph.D., Mary Ann Barr, Ph.D., Fred Chavaria, Ph.D.: Systems approach to substance abuse treatment: The federal model.

1.

2.

AA. Thomas W. White, Ph.D.: Legal and programmatic issues related to the administration of Suicide Prevention programs in correctional facilities.

1.

2.

Midwestern Mental Health in Corrections Symposium Learning Objective Assessment

The learning objectives for this symposium are:

1. Discuss and elucidate policy issues relevant in the delivery of mental health services in correctional settings;
2. Explain and describe the processes involved in relapse prevention strategies with substance abusers and sexual offenders;
3. Describe theoretical perspectives and treatment models in the treatment of sexual offenders;
4. Understand and become familiar with correctional mental health delivery in the United Kingdom.

1. The symposium discussed and elucidated policy issues relevant in the delivery of mental health services in correctional settings.

1	2	3	4	5	6	7
Not at		Not		Some		Completely
All		Really		what		

2. The symposium explained and described the processes involved in relapse prevention strategies with substance abusers and sexual offenders.

1	2	3	4	5	6	7
Not at		Not		Some		Completely
All		Really		what		

3. The symposium described theoretical perspectives and treatment models in the treatment of sexual offenders.

1	2	3	4	5	6	7
Not at		Not		Some		Completely
All		Really		what		

4. The symposium helped me understand and become familiar with the mental health delivery in the United Kingdom.

1	2	3	4	5	6	7
Not at		Not		Some		Completely
All		Really		what		

**Midwestern Mental Health in Corrections Symposium
Workshop Satisfaction Evaluation
Form**

Are you staying at the Adams Mark: YES NO

Please rate each of the following on a scale of 1 to 5;

1 = STRONGLY DISAGREE, 2 = DISAGREE, 3 = NEUTRAL, 4 = AGREE, 5 = STRONGLY AGREE

1. Instructors were well prepared: 1 2 3 4 5
2. Instructors presented their concepts clearly: 1 2 3 4 5
3. Instructors were responsive to questions: 1 2 3 4 5
4. Symposium presentation titles were accurate: 1 2 3 4 5
5. Symposium presentations provided new information: 1 2 3 4 5
6. The teaching styles used were appropriate: 1 2 3 4 5
7. The content level was appropriate to the audience: 1 2 3 4 5
8. There was enough interaction between instructors
and participants: 1 2 3 4 5
9. Audio-visual equipment was used appropriately: 1 2 3 4 5
10. Handouts were current: 1 2 3 4 5
11. Handouts were useful: 1 2 3 4 5
12. Symposium learning objectives were met: 1 2 3 4 5
13. This workshop met my expectations: 1 2 3 4 5
14. I would attend this symposium next year: 1 2 3 4 5
15. May is a good time for me to attend this symposium: 1 2 3 4 5
(A better time would be: _____)
16. Registration was smooth and efficient: 1 2 3 4 5
17. On-site services were helpful and responsive: 1 2 3 4 5
18. The Adams Mark is a good location for this symposium: 1 2 3 4 5
19. Other comments: _____

20. What topic or subject would you like to see in next years symposium?

21. What changes should be made for next years symposium? (Additions/deletions)

REGISTRATION FORM

(Please detach/photocopy and enclose with registration materials)

1992 Midwestern Mental Health in Corrections Symposium

The cost of all conference materials and amenities are included in the registration fee. Please mark and include separate additional payments for the *Jazz and Pub Crawl*. **PLEASE ENCLOSE THIS FORM WITH YOUR HOTEL ROOM RESERVATION FORM.**

NAME: _____ TITLE: _____

COMPANY NAME/AGENCY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: () _____

Registration fees (mark appropriate fees - indicate form of payment):

Conference \$79.00 _____ (Advanced payment required at the time of registration.)

On-site registration \$89.00 _____

Jazz Pub Crawl \$35.00 _____ (Thursday 5/28/92, 7-11 p.m. Transportation and dinner included - NO REFUND for Pub Crawl after April 28. **ADVANCED REGISTRATION NECESSARY.**)

Form of Payment: _____ Check Enclosed _____ Credit Card _____ Purchase Order (attached - not valid with Jazz Pub Crawl, include additional payment)

Please make checks payable to ADAM'S MARK HOTEL and send forms with room reservation to: ADAM'S MARK HOTEL/9103 East 39th Street/Kansas City, MO/64133 (816)737-0200.

All reservations and monies must be received by April 28, 1992. On-site registration fees are \$89.00.

Registration cancellations and refunds prior to May 15 will be subject to a \$10.00 processing fee retained by the Adams Mark Hotel. No refunds will be provided after May 15. Please contact the hotel to obtain a refund fees minus the handling fee.